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This report explains the major considerations in developing group health insurance coverage for public school personnel. A general overview is given of (1) group health insurance coverage, (2) patterns of group health insurance, (3) group health insurance organizations, (4) eligibility and enrollment practices, and (5) continuous health insurance coverage. Developing specifications for group health insurance is discussed in terms of (1) hospital insurance, (2) medical insurance, (3) surgical insurance, (4) major medical insurance, (5) general exclusions and limitations, and (6) group health insurance premiums. Sample contracts of representative group insurance plans are included and maximum allowances and benefits of these plans are presented by State and school district. A short bibliography lists relevant background material. A related document is EA 001 801. (TT)

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Group Health Insurance Plans for Public-School Personnel, 1964-65

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July 1966

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FOREWORD

Group health insurance provides protection from the financial burden of health care for the teacher and his family. More public school systems are accepting the responsibility of providing and paying part of the cost of group health insurance, which may be an incentive in attracting and retaining the finest personnel. The needs and desires of school personnel, combined with a competitive premium rate, should be the basic considerations in the selection and maintenance of a group health insurance plan. These two factors will tend to stimulate full participation and acceptance of the group health insurance plan by all members of the group to be served.

This report is designed to simplify and explain the major complexities and considerations in developing group health insurance coverage. The approach is based on actual experience in public school systems and insurance organizations in providing hospital, medical, and surgical protection. The appeal is to public-school insurance administrators and local education association committees for a proper understanding and knowledge of group health insurance to protect adequately both the school system and the teacher.

This study has been tabulated and reported under the direction of Jack H. Kleinmann, Assistant Director, and Donald P. Walker, Research Assistant. The staff of the Statistics Section and Typing Production Unit were of invaluable assistance in gathering and producing the digest of group health insurance plans.

The Division is most grateful to the many central-office personnel and insurance officials who supplied the flyers, brochures, and policies, and who later checked the accuracy of the reported digests.

HAZEL DAVIS
Director, Research Division

I. INTRODUCTION

In 1964, 79 percent of the civilian population had some protection against hospital care costs; 75 percent had some surgical expense protection; and 57 percent were protected to some extent against the cost of in-hospital medical visits, according to the Health Insurance Association of America.[1] A survey conducted by the NEA Research Division during the 1964-65 school year shows that a majority of school systems cooperate in providing these group health insurance benefits for their staffs.[2] This report, which contains descriptions of group health insurance plans, is one of two reports based on the original, comprehensive study. The other report will contain detailed information on group life insurance provisions.

Scope of the Report

This report, in addition to the introduction, contains five parts:

- II. Overview of Group Health Insurance
- III. Considerations in Developing Group Health Insurance Specifications
- IV. Representative Examples of Group Health Insurance Plans
- V. Digests of Group Insurance Plans for Public-School Personnel, 1964-65, Maximum Allowances and Benefits
- VI. Selected References on Group Health Insurance

Tabulation Résumé

The questionnaire on school system group insurance cooperation for 1964-65 contained a request for printed material or brochures describing the various insurance plans in effect. A wide variety of plans and printed material on group health insurance was remitted by the respondents.

A group health insurance tabulation résumé was prepared to gather information on specific health care coverage. Information recorded on the résumés included specific coverage for hospitalization, medical, surgical, and major medical insurance, all of which was taken from the group health insurance brochures. Separate résumés were used for those school systems which cooperated in more than one group health

TABLE 1.--ANALYSIS OF RÉSUMÉS RETURNED, 1964-65

Enrollment stratification	Total number of operating systems, 1964-65	Number of systems cooperating in providing health insurance	Number of systems reported (usable replies)	Number of usable replies as percent of systems cooperating in providing health insurance
1	2	3	4	5
Stratum 1--100,000 or more	21	21	19	90.5%
Stratum 2--50,000-99,999.	48	45	35	77.8
Stratum 3--25,000-49,999.	73	57	56	98.2
Total, Strata 1-3 .	142	123	110	89.4%
Selected systems--below 25,000 enrollment	72	...	72	...

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[1] Reed, Louis S. "Private Health Insurance in the United States: An Overview." Social Security Bulletin 28: 3-21, 48; December 1965.

[2] National Education Association, Research Division. Employer Cooperation in Group Insurance Coverage for Public-School Personnel, 1964-65. Research Report 1966-R4. Washington, D. C.: the Association, March 1966. p. 7.

TABLE 2.--EXTENT OF EMPLOYER COOPERATION BY TYPE OF GROUP HEALTH INSURANCE COVERAGE, 1964-65

Enrollment stratification	Hospitalization		Medical surgical		Major medical	
	Number	Percent	Number	Percent	Number	Percent
1	2	3	4	5	6	7
Stratum 1--100,000 or more (total respondents--21)	20	95.2%	20	95.2%	16	76.2%
Stratum 2--50,000-99,999. (total respondents--48)	44	91.7	42	87.5	33	68.8
Stratum 3--25,000-49,999 (total respondents--65)	54	83.1	53	81.5	43	66.2
Stratum 4--12,000-24,999 (total respondents--256)	214	83.6	208	81.3	154	60.2
Total, Strata 1-4 (total respondents--390)	332	85.1%	323	82.8%	246	63.1%
Selected suburban systems--enrollment below 12,000 (total respondents--193) ...	179	92.7%	174	90.1%	133	68.9%

insurance plan. Some group health plans offered varying levels of coverage under the same basic plan, graded according to amount or option desired, annual income, or age; these were recorded at the highest option level, $6,700 annual income and age 40, respectively.

Résumés were then returned to the school systems for any additions, corrections, or deletions, and, also, to furnish certain information not available from the brochures. Since there was a time lapse between the original request and the completion of the résumés, school systems were reminded not to update the résumés but to make necessary changes that were in effect for the 1964-65 school year.

Analysis of Résumés Returned

Table 1 furnishes information on the number of résumés sent and the number of résumés returned. All operating school systems cooperating in group health insurance programs in Strata 1-3 (pupil enrollment of 25,000 or more) were sent résumés, as were 72 selected urban and suburban systems with enrollments below 25,000. The 72 systems were selected as representatives in terms of size, geographical location, and variation in health insurance coverage.

Summary of School Employer Cooperation in Group Health Insurance

Group health insurance provides some measure of protection from the financial burdens of health care. Basically, health care may be broken down into three categories: hospital care, medical treatment, and surgical procedures. For each of these categories, many kinds of forms and coverage are available through insurance companies, nonprofit health service organizations, and group-practice associations.

Some health insurance plans distinguish between "basic" health insurance coverage and major medical insurance coverage. In those instances, basic health insurance coverage is generally limited to short-term health care, after which supplementary major medical coverage provides for the prolonged, expensive injury or illness. Recent developments in health insurance have led to the provision of comprehensive major medical insurance plans, which replace basic health insurance plans. Also, the trend is to extend basic health insurance coverage to provide up to two years of hospital care and greater allowances for medical-surgical procedures.

There are two basic advantages in participating in group health insurance coverage: (a) minimum cost in relation to coverage, and (b) coverage for individuals who otherwise would be considered "poor risks."

The summary Tables 2, 3, and 4 on school system cooperation in providing group health insurance were computed from the questionnaire for Employer Cooperation in Group Insurance Coverage for Public-School Personnel, 1964-65. All operating school systems in Strata 1-4 (pupil enrollment of 12,000 or more) were sent questionnaires, as were 203 selected suburban systems with enrollments below 12,000. Usable replies totaled 88.0 percent of the Strata 1-4 systems and 95.1 percent of the suburban systems.[3]

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[3] *Ibid.*, p. 5.

TABLE 3.--PERCENT OF SCHOOL SYSTEMS WHICH COOPERATE, BY COMBINATIONS OF GROUP HEALTH INSURANCE PROVIDED, 1964-65

Enrollment stratification	Number of systems reporting	Hospitalization, medical-surgical, major medical	Hospitalization, medical-surgical (only)	Other	Total--some type of health insurance
1	2	3	4	5	6
Stratum 1--100,000 or more	21	71.4%	23.8%	4.8%	100.0%
Stratum 2--50,000-99,999	48	64.6	22.9	6.3	93.8
Stratum 3--25,000-49,999	65	58.5	21.5	7.7	87.7
Stratum 4--12,000-24,999	256	53.9	26.6	7.0	87.1
Total, Strata 1-4	390	56.9%	25.1%	6.9%	88.7%
Selected suburban systems--below 12,000 enrollment	193	65.8%	24.4%	4.1%	94.3%

TABLE 4.--SCHOOL SYSTEMS WHICH PAY ALL OR PART OF GROUP HEALTH INSURANCE COST, 1964-65

Type of insurance	Total systems reporting 12,000 and over in enrollment				Selected suburban systems, less than 12,000 in enrollment			
	Cooperate		Pay all or part		Cooperate		Pay all or part	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1	2	3	4	5	6	7	8	9
Hospitalization	332	85.1%	131	33.6%	179	92.7%	77	39.9%
Medical-surgical	323	82.8	128	32.8	174	90.1	74	38.3
Supplemental or comprehensive major medical	246	63.1	115	29.5	133	68.9	86	44.6
Total school systems reporting	390	100.0%	390	100.0%	193	100.0%	193	100.0%

School systems may cooperate in one or more ways: by sponsoring, making payroll deductions, or paying all or part of the premium cost of group health insurance. Table 2 shows that of the different types of group health insurance, school systems cooperate in providing hospitalization most frequently, but medical-surgical is very close behind. Far fewer school systems cooperate in providing major medical insurance. This is to be expected, since major medical coverage is a relatively recent development in health insurance.

Table 3 shows that 88.7 percent of the Strata 1-4 systems and 94.3 percent of the suburban systems cooperate in providing one or more types of group health insurance--hospitalization, medical-surgical, or major medical. Over half of the Strata 1-4 systems and 65.8 percent of the suburban systems make available all three types of group health insurance. In addition, approximately one-fourth of the Strata 1-4 and the suburban systems have available basic health insurance coverage consisting of hospitalization and medical-surgical insurance.

Table 4 shows that about a third of Strata 1-4 systems pay all or part of the cost of insurance coverage; the percentage of selected suburban systems which participate in financing group health coverage is somewhat higher for each type of insurance listed.

Competitive Position of School Systems

A survey of approximately 690 reporting companies conducted in 1963 by the U.S. Bureau of Labor Statistics revealed that 97 percent of all industries cooperate in providing hospitalization, surgical, and medical plans, and sickness and accident insurance for their white-collar employees (clerical, technical, professional, administrative, and executive positions). Included in the survey were 289 firms with 250 to 999 employees, and 401 firms with 1,000 or more employees. Of these companies, 74 percent indicated that they paid all or part of the expenditures for these insurance plans; 30 percent paid all the cost.[4]

While the percentage of school employers paying part or all of the premium for employee health insurance has increased somewhat in the past decade, the extent of employer cooperation is by no means as great as is found in private and governmental employment. According to Allen:

> Although the major benefit from a hospital medical plan accrues to the employee, there are specific advantages to the school district. Through better means of preventive health care or early and adequate treatment when illness occurs, employees lose less time due to sickness. This is of particular importance, considering the present high costs for illness-leave payments and the expense of employing substitutes, especially in the teaching services. An adequate plan of hospital-medical coverage tends to improve morale, particularly if the district sponsors the program and contributes toward the cost. An adequate hospital-medical program is an effective tool in meeting competition in a tight labor market. In the recruitment and holding of good personnel, a broad and well-administered hospital-medical plan is of much greater effect than a similar amount of expenditure added to the salary scale.[5]

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[4] U.S. Department of Labor, Bureau of Labor Statistics. Supplementary Compensation for Nonproduction Workers, 1963. Bulletin No. 1470. Washington, D.C.: Government Printing Office, December 1965. Tables 6 and 9, p. 24 and 27.

[5] Allen, Clifford H. School Insurance Administration. New York: Macmillan Co., 1965. p. 104.

II. OVERVIEW OF GROUP HEALTH INSURANCE

National health expenditures stood at $36.8 billion in 1964, 5.8 percent of the Gross National Product. Almost 68 percent ($24.8 billion) of all health expenditures were made by private consumers or health insurance organizations on their behalf. One-third of the total consumer expenditures for personal health care, $7.8 billion, was met by health insurance and the balance, $15.9 billion, represented direct out-of-pocket payments for care.[1]

Group Health Insurance Coverage

Hospital care expenditures constituted the largest single item of national health expenditures and in 1964 accounted for almost 35 percent ($12.7 billion) of the total. Expenditures for the services of physicians in private practice, the next largest component of health expenditures, amounted to $7.3 billion (20 percent). Health insurance coverage provides the protection which more readily enables individuals to meet rising costs in these two major health expenditure areas.

Patterns of Group Health Insurance

Private health insurance organizations provide group health insurance protection for their members in two basic patterns: reimbursement and service.

The common feature of reimbursement, or indemnity, health insurance is the application of maximum amounts. Generally, maximum amounts are applied in two ways:

1. Scheduled maximum amounts for specific items or procedures
2. Over-all maximum amounts limited to a specific illness, number of years, or some other form of time measurement.

The reimbursement payments may be made to the insured individual for health expense incurred, or assigned directly to the hospital or physician for benefits provided.

Service plans provided the insured with specific scheduled or nonscheduled benfits or health care offered through service plans is provided either by prearranged agreements with participating hospitals and physicians (Blue Cross-Blue Shield) or through group practice medical facilities and staff physicians.

Various combinations of reimbursement and service insurance patterns have been developed to provide a wide variety of coverage.

Group Health Insurance Organizations

Group health insurance organizations have been grouped into three different types: insurance companies, nonprofit health service organizations (Blue Cross-Blue Shield), and group-practice associations. Some individuals may be enrolled in more than one of the three types of organizations. Of the total enrollment in insurance organizations at the end of 1964, approximately 60 percent of the persons were covered by insurance companies, 36 percent by Blue Cross-Blue Shield, and 4 percent in group-practice associations.[2]

Insurance Companies

The group health insurance policy is contracted between the insurance company and the member's organization. The policy will specify the amount of reimbursement and conditions for which payment will be made under the group coverage. The insurance company will reimburse the insured individual directly for approved claims, or, if preferred, the individual may assign payment to the hospital and doctor. Members covered under the group health insurance carrier's policy can usually recieve medical treatment in any accredited hospital or by any licensed doctor. Insurance carrier's policies generally follow the indemnity pattern in insurance coverage. Over 1,000 insurance companies wrote group insurance policies in 1963.

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[1] Reed, Louis S., and Hanft, Ruth S. "National Health Expenditures, 1950-64." Social Security Bulletin 29: 3-19; January 1966. p. 3 and 6.

[2] Reed, Louis S. "Private Health Insurance in the United States: An Overview." Social Security Bulletin 28: 3-21, 48; December 1965. p. 10.

Nonprofit Health Service Organizations

Blue Cross and Blue Shield are by far the largest nonprofit health service organizations. At present, there are 76 Blue Cross associations and 74 Blue Shield associations in the United States. Generally, these associations are independent, locally governed, nonprofit corporations serving the general geographical area in which they are situated.

Although most associations are independent and sometimes in competition with each other, they are coordinated by their respective national associations. The national associations coordinate interplan arrangements for transfer of membership, without loss of status, for a member who moves or receives service benefits in another association's area.

Blue Cross and Blue Shield offer numerous individual or group plans through participating member hospitals and doctors. Almost all of the accredited hospitals and licensed physicians in a covered area are participants and under contract with the Blue Cross or Blue Shield association.

The group plan usually requires a certain percentage of enrollment. Plans vary according to types of services and benefits, amounts and schedules of allowances and specified procedures and treatment. These service plans may also incorporate an indemnity type feature, whereby the plan pays only a specific amount and the member is responsible for additional charges. This feature is usually based on annual income; within specified annual income levels, the physicians agree to accept the schedule of allowances as payment in full.

Group Practice Associations

Group-practice plans are established on a cooperative prepaid basis. The larger plans generally provide, in addition to needed hospital, medical, and surgical care, diagnostic and preventive care in their own clinics or hospitals with salaried medical staffs; other plans provide their own medical care and contract out for hospital care. Even though health coverage is much broader under group-practice plans, the physical facilities and staff members are the limiting factors. In cases of emergency, some plans provide minimum coverage outside the service area until the patient can be moved to their own facilities. Another feature in some plans is a slight charge for certain services, such as doctor's office and home calls and full maternity benefits. Group-practice plans have been organized by community-consumer groups, employer-employee groups, and private medical societies. They are presently available only in the large population centers. The major group-practice plans are the four Kaiser Health Plans (in Northern California, Southern California, Oregon, and Hawaii); Group Health Association of Puget Sound; Health Insurance Plan of Greater New York; Group Health Association of Washington, D.C.; and Community Health Association of Detroit.

Eligibility and Enrollment Practices

Some state statutes govern the minimum number of individuals who must participate in group insurance before a policy may be issued. Also, many insurance organizations require a certain percentage of eligible employees to maintain enrollment under a group policy, along with other standards which must be met before an individual may be eligible for group enrollment. Within these limitations, it is usually the purchasing organization which determines the employees who will be offered the opportunity to participate in the group plan.

Eligibility and enrollment procedures are very closely allied. The initial enrollment period is usually immediately or within 30 days of employment for eligible employees. If an employee waives his initial enrollment opportunity, he may have to wait from three months to a year and provide evidence of "good health" to obtain group coverage.

Continuous Health Insurance Coverage

Membership in the group health insurance plan usually terminates when the individual terminates his employment. However, if the group plan contains conversion privileges, the individual may maintain continuous health insurance coverage. A conversion privilege clause permits the individual to change to an individual contract upon termination of employment. Some group plans make special provisions which allow retired employees and their dependents to remain members in the group plan. Application for the individual policy must be made within a specific time period, and rates are adjusted according to age, dependents, health, and choice of plan.

Special attention on the part of many interests has been given to provide health protection for elderly persons. The most significant development was the Social Security Amendments of 1965 which provide for "medicare." Beginning July 1, 1966, all eligible persons 65 and over who have enrolled will receive hospital insurance protection. In addition, voluntary medical insurance is provided at a low premium ($3 monthly) with the federal government matching this amount. Groups developing health insurance programs should be aware of these services currently available to retired individuals.

Hospitalization is provided for up to 90 days in a "spell of illness." After a $40 deductible, the first 60 days of hospital expense is covered in full; thereafter, 30 of such care is provided except for $10 daily which must be paid by the patient. The medical insurance program pays 80 percent of the reasonable charges for covered expense, except for the first $50 in a calendar year.

Some items and services not covered by either plan are routine physical checkups, eyeglasses, hearing aids, private duty nursing, custodial care, and personal services. Drugs are covered only in the hospital or if administered by a physician.

III. CONSIDERATIONS IN DEVELOPING GROUP HEALTH INSURANCE SPECIFICATIONS

Specifications should be clear, concise, and as comprehensive as possible. Allowable limitations and restrictions should be completely covered along with the areas of protection desired. When specifications are complete and reflect fully the coverage desired by the group, little or no deviation should be permitted while receiving bids or during negotiations, without a full explanation by the prospective company. The reason for this caution is that changes in specifications make it exceedingly difficult to evaluate the different types of protection offered by various companies.

While under present health plan arrangements, amounts and types of benefits vary considerably, there are specific provisions that can be compared for both reimbursement and service plans. A preliminary investigation is necessary to determine the most desirable type of group health coverage available (see Section IV).

Actual benefits should be compared rather than maximum amounts, along with specified exclusions and restrictions. The ultimate determination will depend on the group's desired coverage consistent with a competitive premium level.

One important question to be considered is that of dependent coverage--how much and for whom? Most group plans provide the same health coverage for dependents as for employees. Children are usually covered from birth or from 14 days after birth. Recent trends have been to expand the upper age limit from 19 to 23, so long as the child is single and going to school. The immediate family unit is still the most common guideline in considering who is a dependent.

Hospital Insurance

The group health insurance organization determines the hospital or other medical facilities that the member may use, e.g., any accredited hospital, member accredited hospital, nursing home, and clinic. Following are factors (and comments) which should be considered in developing specifications for hospital insurance:

1. Conditions or causes excluded from hospital admission coverage. (See general exclusions, page 14.
2. Minimum confinement before hospital coverage goes into effect. Generally, the minimum confinement is not more than 18 hours before coverage commences.
3. Scope of daily benefits and service. Most often room and meals, general nursing care, and special diets are included.
4. Maximum allowance for hospital room. Allowances are generally provided on an "up to" basis. This means that the patient will be reimbursed for charges up to the allowance shown in the digest.
5. Type of accommodation. Accommodations vary from private to ward; these should be defined in the policy according to bed capacity.
6. Flexibility of daily allowance or accommodations. If the physician prescribes better accommodations for the patient than covered under the plan, is the cost of daily coverage applied toward these better accommodations.
7. Maximum number of days allowed for each hospital confinement. Consecutive days of coverage for each confinement are usually not less than 21 days, and may be as high as two years.
8. Waiting period before maximum benefits may be renewed. Some maximum hospital confinement benefits are available once each contract term. Others are renewable after an appropriate out-of-hospital waiting period of 30 to 90 days.
9. Other hospital services, including cash allowances or services provided in addition to daily benefits. Services vary considerably from full coverage, maximum amounts, and specific lists of items covered for each hospital confinement (e.g., drugs, supplies and medications, laboratory examinations, and the use of operating room).
10. Emergency outpatient care in case of accident. Treatment must usually be obtained within a specific number of hours after the accident occurs.
11. Diagnostic treatment or examination. Generally applicable after the illness has

been determined, except under group-practice plans which provide full diagnostic coverage.

12. Maternity and newborn child care. If provided, consider carefully as these are usually handled separately from other hospital confinements, and usually are not provided under individual coverage.

Medical Insurance

Medical insurance covers medical treatment by a physician in the hospital for surgical or nonsurgical confinement, in the doctor's office, or at the patient's home. Medical care is most often provided in the hospital for nonsurgical conditions. Additionally, if coverage is available in all three situations, allowances are usually much greater for in-hospital treatment. When home and office calls are covered, they are generally limited to the employee, with some plans charging a minimum fee for service. Following are factors (and comments) which should be considered in developing specifications for medical insurance:

1. Number of days or visits allowed for each place. Visits are usually limited to one per day. The number of days allowed for in-hospital medical treatment may differ from the hospital confinement period.

2. Allowance for each day or visit, and maximum amount allowed for each location. Allowances are usually more liberal for in-hospital medical care than for care provided in the home or doctor's office.

3. Waiting period before medical coverage goes into effect. May vary for illnesses not requiring hospitalization as opposed to those requiring hospital admission.

4. Waiting period before maximum benefits may be renewed. May not be the same as provided under hospital insurance.

5. Maternity and child care. Prenatal and postnatal care is usually not provided except under group practice plans.

6. Consulting physicians and specialists as needed. Allowances vary considerably but generally must be requested by another physician.

7. Diagnostic treatment and examination. Generally applicable after the illness has been determined except under group-practice plans which provide full coverage.

8. Preventive care and medical check-up. Not provided except under group practice plans.

9. Psychiatric treatment of mental or nervous disorders. Generally not covered except under major medical provisions.

Surgical Insurance

Whether surgical procedures are scheduled or nonscheduled, amounts are usually provided for under a "reasonable" charge clause in the policy. The "reasonable" charge is a charge not out of line with charges for the same or similar type surgical procedures in the general area. Although the following factors are considerations for a scheduled listing of surgical operations, they may also be the basis for the "reasonable" charge allowance:

1. Amount and types of surgical operations listed. Some provision should be made for nonscheduled operations and minor surgery not requiring hospitalization.

2. Maximum allowance for a single operation. The higher the maximum, the less restriction on unexpected, complex procedures. Single operation maximums range from $200 to over $1,000.

3. Multiple surgical procedures. Allowances for multiple procedures depend on their relationship to the original operation. Generally, the highest amount is allowed, with various arrangements for the other procedures.

4. Coverage for anesthesia and anestheist. Coverage is provided in various ways: by the number of hours of service required, as a percentage of operation cost, separate amounts for each operation, or as part of the total surgical procedure allowance.

5. Obstetrical procedures. Benefits described in Section IV are for normal delivery. Scheduled obstetrical procedures usually provide higher benefits in those cases where obstetrical complications arise. Other methods of providing obstetrical procedures are covered by lump-sum or fee-for-service arrangements which include other maternity benefits covered under a single amount.

6. Surgical assistants and consultants. This item may be specifically included, specifically excluded, or not mentioned in the policy.

Major Medical Insurance

Some major medical insurance plans list specific benefits and allowances similar to those designated above, which limit the charges covered within the over-all maximum amount. Generally, actual expense reimbursement is provided on a coinsurance basis after a deductible is paid by the member.

Major medical insurance is applied in two ways--supplementary and comprehensive.

Supplementary major medical insurance extends the basic health coverage; comprehensive plans have tended to replace basic health coverage. Following are factors (and comments) which should be considered in developing specifications for major medical insurance.

1. Conditions and causes excluded from major medical insurance. See general exclusions, below.

2. Amount of deductible paid by member. Various amounts or one maximum amount may be applied to different types of health care, before expenses are covered. Out-of-pocket deductibles vary from $25 to over $500 but most often will be about $100.

3. Application of deductible: initial or corridor. Initial deductibles are used in comprehensive major medical plans and are applied before any payments by coinsurance for a particular type of covered expense. Corridor deductibles pertain to supplementary major medical plans and are applied after basic plan benefits are exhausted and before supplementary major medical payments commence on a coinsurance basis.

4. Time allotted for payment of deductible. Varies from 90 days, 6 months, 1 year, or in relation to a particular illness.

5. Coinsurance provisions. Percentage of shared covered expense; 80 percent paid by insurance company, 20 percent paid by member is typical, but numerous other arrangements are available.

6. Maximum amount or upper limit. Ranges from $5,000 to $40,000 with most plans providing up to $10,000.

7. Time limit on payment of maximum amount. Some measure of time is generally attached to the payment of the maximum amount, whether it be per illness, number of years, or life.

8. Reinstatement of maximum amount. The maximum amount is usually reinstated after $1,000 in benefits has been paid. Sometimes reinstatement is automatic, but more often it occurs after proof of good health is furnished.

9. Common family accident deductible. This provides one deductible rather than individual deductibles in case of a common family accident.

10. Outpatient psychiatric care. If covered, outpatient psychiatric care is sometimes reimbursed on a lower coinsurance basis (e.g., 50-50) than other types of coverage.

General Exclusions and Limitations

All types of health insurance plans generally contain some exclusions. The most common exclusions are dental care, cosmetic surgery, alcoholism, drug addiction, venereal disease, attempts at suicide or other intentionally self-inflicted injuries or illnesses, tuberculosis, conditions covered by Workman's Compensation laws, military service-connected conditions, service rendered by government hospitals, and conditions caused by war. Still other health insurance plans exclude health examinations, normal eye and ear examinations, glasses or hearing aids, corrective appliances and artificial aids and blood or blood plasma. Provisions for maternity care, appendectomy, tonsillectomy or hernia coverage may require a waiting period before they can be considered covered expenses. These exclusions are enumerated in the group policy. Other limitations, not specifically included in the insurance policy, are the scope of facilities and variety of professional personnel made availabe by the insurance organization from which a subscriber may choose, by desire or necessity, to receive health care.

Group Health Insurance Premiums

The cost of providing the same benefits may vary considerably from one group to another depending on differences in composition of the group. Premiums are determined by a number of factors:

1. The scope of benefits desired.

2. The occupations of the members of the group: i.e., the element of risk inherent in the occupations of the group members affects the cost of certain benefits.

3. The numbers of men and women in the group: experience indicates that, on the average, women make more claims for certain benefits than do men.

4. The ages of the group members.

5. The size of the group: generally, the larger the group and the greater the volume of premiums, the lower the initial and ultimate cost of the plan. (This is known as a "premium-volume discount.")

6. The number of group members who have dependents: the cost of benefits for dependents varies in direct proportion to the number of dependents covered.

The first year's premium is determined on the basis of the foregoing factors. The premiums for following years are determined by experience-rating, or by what is known as the "cost-plus" basis, the "cost" being the actual claim payments made by the insurance company during the preceding year and the "plus" being the amount the insurance company retains for its operating expenses and profit. If the claim experience is greater than anticipated, the premium, of course, is raised; conversely, if the claim experience is less than anticipated, the premium is lowered.1/

Health service organizations, such as Blue Cross and Blue Shield, used to determine their premiums on a "community-rated" basis but recent trends, due to competition from insurance companies, have caused them to change to the "experience-rated" basis. Under the community-rating approach, the entire service plan area was considered a group and the premium for basic coverage was the same for all participants.

1/ Jack H. Kleinmann. Fringe Benefits for Public School Personnel. (New York: Bureau of Publications, Teachers College, Columbia University, 1962), pp. 18-19. Quoted with permission.

IV. REPRESENTATIVE EXAMPLES OF GROUP HEALTH INSURANCE PLANS

The examples of group health insurance policies included in this section were selected to illustrate the types of plans different organizations provide for local school systems to give some protection against the expenses of hospital care, medical treatment, and surgical procedures. Many variations of these basic types of coverage are available; each group to be insured must determine the group health plan which best fulfills its particular needs.

Example 1 is a basic health insurance plan with supplementary major medical insurance provided by nonprofit health service organizations (Hospital Service Corporation of Rhode Island and Rhode Island Medical Society Physicians Service--Blue Cross and Blue Shield). There are three separate contracts provided: hospital care (Blue Cross), surgical-medical care (Blue Shield), and supplementary major medical care (issued jointly by Blue Cross and Blue Shield). The basic health insurance can be contracted for separately from supplementary major medical care. In some instances, supplementary major medical care is underwritten separately by either Blue Cross or Blue Shield and in other instances by an independent insurance company. The plans in this example are available only in the Rhode Island Blue Cross and Blue Shield service area, but similar plans are available elsewhere.

Example 2 is a comprehensive major medical care plan provided by an independent insurance company (The Equitable Life Assurance Society of the United States). This group health plan illustrates several features: (a) conditions for deductible amount, (b) scheduled allowances along with the maximum amount, (c) special provisions which limit the extent of maternity and psychiatric treatment. Variations of comprehensive major medical insurance are available through the addition or deletion of special provisions.

Example 3 is a basic health insurance plan provided by a group-practice association (Kaiser Foundation Health Plan, Inc.). The Kaiser plan, like other group-practice plans, provides diagnostic services on a preventive basis as well as medical treatment after an illness or disability occurs. The Kaiser Foundation follows a policy of dual choice, which means that at least two organizations must be available to provide health care; each employee thus may choose between the Kaiser plan and the other plan, depending upon which comes closest to meeting his individual needs. The Kaiser plans are available only to groups within their specific service area.

BLUE CROSS CONTRACT
for Hospital Care

®

RHODE ISLAND BLUE CROSS
PROVIDENCE, RHODE ISLAND

A Non-Profit Community Service, Incorporated Under the Laws of Rhode Island.

®Approved by American Hospital Association

This contract is made between the Hospital Service Corporation of Rhode Island (hereinafter called the Corporation) and the Applicant named in the application to receive the benefits provided herein and whose name and identification number appear on the membership card furnished to said Applicant.

In consideration of the application and upon payment in advance of the subscription charges, the CORPORATION agrees to furnish and provide to said Applicant and each Subscriber, if any, listed on the application or reclassification thereof, hospital care according to the Blue Cross Plan described on the following pages which is part of this contract.

In Witness Whereof, the HOSPITAL SERVICE CORPORATION OF RHODE ISLAND has executed this Contract.

HOSPITAL SERVICE CORPORATION
OF RHODE ISLAND

By: George C Davis
President

Attest:
Secretary

Countersigned: Arthur F. Hanley
Executive Director

Series C-P-D-F-J (7-1-65)

THE BLUE CROSS PLAN FOR HOSPITAL CARE

PART I — HOSPITAL BENEFITS PROVIDED

Each subscriber in good standing, if in need of care in an approved hospital for illness, or injury, upon admission to a hospital as a bed patient, on and after the effective date of this agreement, shall be entitled to credits for hospital services and supplies while such care is medically necessary, subject to the terms and conditions of this agreement, for the length of time specified in Part II of this agreement, as follows:

(a) FOR MEDICAL AND SURGICAL CASES

(i) If the subscriber is hospitalized in a MEMBER HOSPITAL or SERVICE BENEFIT HOSPITAL, up to the amount per day indicated on the membership card (under "R & B"), as a credit towards the usual hospital charges for (1) room accommodations, (2) dietary service and meals, and (3) general nursing care (items (1) through (3) being hereinafter referred to as ROUTINE SERVICES) and, IF IN A MEMBER HOSPITAL OR SERVICE-BENEFIT HOSPITAL, the full amount of the hospital's usual charges for (4) use of operating room, (5) medical and surgical supplies, and drugs and medications as most currently listed in either the "U. S. Pharmacopeia" or "New and Non-Official Remedies", (6) laboratory examinations, (7) basal metabolism tests, (8) oxygen therapy and (9) physical therapy (items (4) through (9) being hereinafter referred to as SPECIAL SERVICES).

(ii) If a subscriber is hospitalized in cooperating member hospital of another Blue Cross Plan with which the Corporation has a reciprocal agreement, such subscriber shall receive credits for all benefits provided by the Reciprocating Plan under such agreement. If the total of the credits received from the Reciprocating Plan is less than the subscriber would have received in a MEMBER HOSPITAL, the subscriber shall, upon written request, be entitled to credit from the Corporation for the difference; provided that if his contract is for semi-private coverage, he shall be entitled to credit from the Corporation for the difference between the credits received for ROUTINE SERVICES from the Reciprocating Plan and, if more, the average cost of semi-private rooms in Rhode Island Member Hospitals.

(iii) If a subscriber is hospitalized in a member hospital of another Blue Cross Plan with which the Corporation does not have a reciprocal agreement, such subscriber shall receive credits for ROUTINE SERVICES as described for a Member Hospital, and for the SPECIAL SERVICES referred to above, 90% of the hospital's usual charges as a credit towards the charges for such services.

(iv) If the subscriber is hospitalized in a non-member hospital, such subscriber shall receive credits for ROUTINE SERVICES as described for a Member Hospital, and for the SPECIAL SERVICES referred to above, 90% of the hospital's usual charges, as a credit towards the charges for such services.

(v) Each of the above subparagraphs are subject to special provisions, if any, shown on particular membership cards.

(b) FOR MATERNITY CASES

Up to $110 for each pregnancy as a credit toward usual hospital charges to the subscriber for both ROUTINE SERVICES AND SPECIAL SERVICES during a hospital admission for delivery, or such other amount as may be shown on the membership card.

If care beyond the 5th day of hospitalization during any admission resulting in delivery is medically necessary, the subscriber shall also be entitled to the credits set forth for MEDICAL AND SURGICAL CASES in paragraph (a) above beginning on the 6th day of hospitalization.

Admissions for false labor will be entitled only to the credits set forth in paragraph (a) above.

Subscribers requiring Caesarean delivery or other major surgical procedures relating to maternity will be entitled to the credits set forth for MEDICAL AND SURGICAL CASES in paragraph (a) above, or to credits for MATERNITY CASES as set forth in this paragraph (b), whichever are greater.

In cases receiving benefits under paragraph (a) no credit is available for services rendered the newborn child until he or she shall become a subscriber (except as otherwise indicated on the membership card). Each newborn child shall become a subscriber entitled to all benefits of membership (i) when a major surgical procedure is performed on the child, (ii) when the mother or child is discharged from the hospital, or (iii) when the child has attained the age of 14 days, whichever event shall first occur. The above maternity case credits (whether allowed under paragraphs (a) or (b) above) are available only if the patient and her husband have both been subscribers under the same subscription agreement for a waiting period of 7 months immediately prior to admission. (The 7 months' waiting period is waived for subscribers under the Comprehensive Plan.)

Cases involving any of the following complications of pregnancy, which do not result in delivery, will be entitled to the credits set forth for MEDICAL AND SURGICAL CASES in paragraph (a) above without a waiting period, provided the patient and her husband are both subscribers under the same subscription agreement, otherwise such cases will be entitled to no credits:

Any pregnancy terminating before expiration of 26 weeks, ectopic pregnancy, miscarriage, or abortion
Placenta previa or placenta abruptio.

Aggravation of a heart condition or of diabetes.

Hyperemesis gravidarum.

Toxemia.

Premature rupture of membranes.

Threatened miscarriage.

Cases which result in delivery, involving any of the above complications of pregnancy, shall, from the date of admission to and excluding date of delivery, be entitled to the credits set forth for MEDICAL AND SURGICAL CASES in paragraph (a) above. Upon and after the date of delivery, such cases shall be entitled to the credits set forth in the first subparagraph of Part I (b) above, but if care is medically necessary beyond the 5th day of hospitalization from and including the day of delivery, the credits set forth in the second subparagraph of Part I (b) will apply.

PART I — HOSPITAL BENEFITS *continued*

(c) FOR OUT-PATIENT SURGICAL CASES

Up to $7.50, or such larger amount as may be shown on the membership card, as a credit towards the hospital's usual charges for SPECIAL SERVICES rendered a subscriber who, as an out-patient of the hospital, requires the use of an operating room for an operation involving (i) a cutting procedure, (ii) the administration of a general anesthesia, or (iii) the reduction of a fracture or dislocation.

(d) ACCIDENT ROOM CASES

Up to $7.50 or such larger amount as may be shown on the membership card, as a credit towards the hospital's usual charges for the use of its Accident Room facilities and SPECIAL SERVICES rendered a subscriber during the initial visit within 24 hours following a traumatic or poisoning accident.

(e) COVERAGE UNDER MORE THAN ONE AGREEMENT

A subscriber entitled to benefits under more than one subscription agreement of the Corporation shall be entitled to the aggregate of the credits provided under whichever of paragraphs (a) through (d) of Part I of the several agreements may be applicable, but not exceeding the total charge for the services rendered under those paragraphs, nor shall such additional coverage increase the duration of benefits specified in this agreement. A subscriber entitled to benefits under subscription agreements of the Corporation and of another Blue Cross Plan shall be entitled to receive credits for all of the benefits provided by both plans, but not exceeding the total charges for hospital services rendered to the subscriber nor to benefits from the Corporation longer in duration than specified in this agreement. Substitution of subscription agreements under which a subscriber is entitled to benefits, or termination of one agreement and entry into another agreement, shall not increase the duration of benefits specified in this agreement.

(f) Any hospital charges in excess of the maximum credits specified above shall be the obligation of the subscriber and not the Corporation. Credits accruing to a subscriber under this agreement may be used only for payment directly from the Corporation to the hospital of outstanding charges giving rise to such credits, and a subscriber shall not be entitled to a cash payment in lieu of having such credits so applied, except that the Corporation may elect to make such payment to the subscriber where services are rendered by a NON-MEMBER HOSPITAL.

PART II — EXTENT AND DURATION OF HOSPITAL CARE

(a) When admission is to a MEMBER HOSPITAL, SERVICE-BENEFIT HOSPITAL, or any other HOSPITAL classified as a SHORT-TERM GENERAL HOSPITAL by the American Hospital Association and/or acceptable to the Corporation as such (except as provided in Part II (b)), each subscriber is entitled to receive credits for hospital services as specified in Part I of this agreement for each period of hospitalization up to 120 days, or such other number of days as may be shown on the membership card, except that each admission, if approved, shall be for a period of 15 days of care. Approvals of additional periods of 15 days each will be given if the attending physician certifies as to the medical necessity of each such additional period and the medical advisor(s) of the Corporation concur therein.

Successive periods of hospitalization in any type or types of hospital during a period in which this agreement or any earlier agreement is or was in force shall be deemed to be continuous and to constitute a single period of hospitalization if discharge from and subsequent admission to any hospital or hospitals occur within a 90 day period, provided that if either such discharge or subsequent admission within such 90 day period shall be for maternity care or complications of pregnancy or treatment of bodily injury to which either the condition at the respective prior discharge or subsequent admission is unrelated, then such subsequent admission shall be deemed for a separate period of hospitalization.

(b) When admission is to a hospital operated by the State of Rhode Island or is to any hospital other than those referred to in Part II (a), each subscriber is entitled to receive credits for hospital service as specified in Part I of this agreement for each period of hospitalization up to 45 days, or such other number of days as may be shown on the membership card, except that each admission, if approved, shall be for a period of 15 days of care. Approvals of additional periods of 15 days each will be given if the attending physician certifies as to the medical necessity of each such additional period and the medical advisor(s) of the Corporation concur therein, provided that:

(i) No subscriber shall be entitled to receive such credits under this Part II (b) for more than 45 days in the aggregate in each calendar year.

(ii) If discharge from a hospital of the type specified in Part II (a) or Part II (b), respectively, and subsequent admission to a hospital of the type specified in Part II (b) or Part II (a), respectively, shall occur within a 90 day period, the same shall be deemed to be continuous and to constitute a single period of hospitalization for the purpose of computing the 120 day limitation prescribed in Part II (a); and in no case shall further credits beyond 120 days be given under Part II (b) and/or Part II (a) unless a 90 day period following discharge shall intervene before readmission.

(iii) If a subscriber is admitted to a hospital of the type specified in this Part II (b) and has during the same calendar year been discharged as a patient from such a hospital more than 90 days prior to such admission, the subscriber shall be entitled to (a) credit for so many of the 45 days during the calendar year as have not theretofore been used, and (b) if such admission on or after November 17th in any year continues into the next calendar year and credits for 45 days during the calendar year of admission are not exhausted during the calendar year of admission, the subscriber shall receive credits during the next calendar year on that same admission for so many of the 45 days as have not been used in the calendar year of admission.

(iv) A subscriber will be entitled to receive credits upon admission to a hospital of the type specified in Part II (b) only if in need of medical care of the type provided by such hospital.

(c) In computing the number of days for which credits for hospital services are available, the day of admission shall be counted, but not the day of discharge. Benefits shall end on the day prior to the day of discharge, or, if earlier, on the day prior to that on which care in an acute general hospital (as to admissions under Part II (a)) or in a hospital of the type specified in Part II (b) (as to admissions to such hospitals) is no longer medically necessary.

PART III — BENEFITS NOT PROVIDED

This agreement does not include the following services except as specifically noted on the membership card:

(a) Hospital admissions solely for diagnostic examinations not incidental to care and treatment as a bed patient; nor hospital services not specifically mentioned in Part I, as by way of example and not by way of limitation , X-ray, X-ray or radium treatment, electrocardiography, electroencephalography, ambulance services, intensive nursing care services, private nurses and their board; nor services of blood donors and testing or typing their blood; nor for blood or blood plasma or charges for its administration; nor payment for an attending physician in rendering any surgical or medical treatment.

(b) Hospital care (i) for any personal injury (including any occupational disease or condition as defined in Workmen's Compensation laws) arising out of and in the course of employment, connected therewith and referable thereto, except in the case of a self-employed person; or (ii) provided by, or paid for by the United States or any of its agencies.

(c) Care which is not necessary in an acute general hospital (as to an admission under Part II (b)), or in a hospital of the type specified in Part II (b) (as to admission to such a hospital), and services and supplies not medically necessary for diagnosis or treatment of an illness, injury, or bodily malfunction.

(d) Custodial care, rest cures, or care in convalescent or nursing homes or homes for the aged.

(e) Hospital care for any condition, disease or injury which existed on or before the effective date of this agreement. (This paragraph (d) does not apply to hospital admissions occurring after 7 months continuous membership nor at all under the Comprehensive Plan.)

(f) Services charged for by the hospital for any day on which the subscriber leaves the hospital premises for all or any portion of the day, except for purposes of treatment elsewhere.

(g) Services and supplies for personal comfort, such as radio, telephone, television, air conditioner, beauty and barber services.

(h) Charges, if any, made by the hospital on account of a delay in departure beyond the regular discharge time.

PART IV — CHANGES

An applicant who does not include his spouse and/or children on his application may add such family members only on the anniversary of the effective date of his Direct Payment membership or of the Group of which he is a member, whichever is applicable. An applicant who later marries may, within 60 days of such marriage, add his spouse to his membership by application to the Corporation if a Direct Payment membership, or, if a Group membership, by application to the person who remits payments for the Group; after 60 days he may add his spouse on the anniversary date as indicated above. An applicant who included his spouse and/or children may remove such family members from his membership only as of a date subsequent to the request for removal when subscription charges are payable.

PART V — TERMINATION AND REFUND

(a) If a Direct Payment membership, this agreement shall continue in force until a default shall exist for 15 days in the payment of subscription charges, or until the effective date, during such period of default, of any new agreement the applicant may enter into with the Corporation, in either of which cases this agreement shall automatically terminate. The Corporation may reinstate this agreement at its sole discretion, but only to cover any illness or injury first manifesting itself more than 15 days after reinstatement, except that such limitation will expire at the end of 7 months of continuous membership following reinstatement.

(b) An applicant subscriber holding a Direct Payment membership who joins a group at his place of employment may continue to maintain his Direct Payment membership independently of his new group membership provided he makes written request to the Corporation, prior to the effective date of his new Group membership, or indicates his intent in the space provided on the Group application card. In the absence of such request this agreement will automatically terminate on the effective date of the new Group membership. In such cases the applicant will be eligible for a refund of that portion of the Direct Payment subscription charges paid beyond the effective date of the new Group membership and any subsequent payment of Direct Payment subscription charges when due will be accepted as a request for reinstatement of the Direct Payment membership as of such due date. A change or transfer from Direct Payment membership to new Group membership will not adversely affect eligibility for benefits based on continuity of membership.

(c) If a Group membership, this agreement shall continue in force until a default shall exist for 30 days in the payment of subscription charges, or until the effective date, during such period of default, of any new agreement the applicant may enter into with the Corporation, in either of which cases this agreement shall automatically terminate. Any applicant who leaves his place of employment may join a group at his new place of employment or enroll on a Direct Payment basis in accordance with the Enrollment Regulations of the Corporation.

(d) The Corporation reserves the right to terminate this agreement at any time upon giving 15 days prior written notice to the Applicant. It may also, upon like notice at any time and from time to time, amend this agreement or any portion thereof and redetermine and fix the amount of subscription charges as it may deem necessary; provided, however, that each such amendment or change of subscription charges shall be effective as to this agreement only upon the expiration of the term for which the subscription charges have been paid. Notice shall be deemed to have been given to each subscriber entitled to benefits hereunder when mailed to the applicant at his address which appears upon the records of the Corporation, or when mailed to the applicant's agent, or when published in a daily newspaper published in the State of Rhode Island. Payment of subscription charges after the giving of notice of an amendment or change in subscription charges shall constitute an acceptance thereof in behalf of all subscribers entitled to benefits hereunder.

(e) The Corporation shall be relieved of all liability to provide credits for hospital services after the date of termination, except that if such termination occurs while a subscriber is confined as a bed patient in a hospital such subscriber shall be entitled to benefits in accordance with this agreement during such hospital stay.

(f) In the event of termination of this agreement within 8 months prior to the birth of a child to any subscriber who would otherwise be entitled to maternity benefits specified in Part I (b) of this agreement and when such subscriber maintains continuous membership by entering into a new agreement with the Corporation, which is in effect at the time of the child's birth, shall be entitled to the maternity benefits under whichever of the agreements provides the greater benefits, but not to the benefits of both.

(g) An applicant who terminates his membership, other than as provided in Part V (b) above, may do so effective as of the last day of the month in which the Corporation receives applicant's written request to terminate. He shall be entitled to a refund of any prepaid subscription charges applicable to periods following such effective date of termination.

PART VI — GENERAL CONDITIONS

(a) The effective date of this agreement shall be that indicated on the application on file with the Corporation.

(b) All claims under the subscription agreement must be filed with the Corporation within 60 days after the services shall have been rendered. The maximum liability of the Corporation hereunder for hospital services rendered to any and all parties for any particular disability shall not exceed that specified in Parts I and II. The benefits of this subscription agreement are non-assignable.

(c) This agreement is made upon the express condition that any hospital or physician is authorized to disclose to the Corporation any information regarding or acquired in connection with the attendance, care or treatment of any subscriber hereunder and that all provisions of law or professional ethics forbidding such disclosures are waived by or in behalf of each subscriber hereunder.

(d) The applicant agrees that the applicant's agent may make available to the Corporation for inspection any employment and other personnel records which have a bearing upon the eligibility of the Enrolled Group, the applicant or any subscriber.

(e) The benefits available hereunder may be extended by action of the Board of Directors of the Corporation, but no subscriber shall be entitled to share in any assets, reserves, or other funds or property now or hereafter owned, acquired, or accumulated by the Corporation.

(f) The Corporation is under no obligation to provide hospital accommodations and neither the Corporation nor any of its Directors, officers or employees shall be liable for any act, omission or neglect of any hospital, its servants, agents or employees, or of any physician or surgeon.

(g) No action or suit at law or in equity shall be commenced under the subscription agreement until 30 days after written notice of claim has been given by the subscriber to the Corporation, nor shall such action be brought at all later than one year after the services on which such claim is based shall have been rendered.

(h) In the event any hospital service or benefit is provided for, or any payment is made or credit extended to, a subscriber under this agreement, the Corporation shall be subrogated and shall succeed to the subscriber's right of recovery therefor against any person or organization, except insurers on policies of insurance issued to and in the name of the subscriber. The subscriber shall pay over to the Corporation all sums recovered by suit, settlement or otherwise, on account of such hospital service or benefit. The subscriber shall take such action, furnish such information and assistance, and execute such assignments and other instruments as the Corporation may require to facilitate enforcement of its rights hereunder, and shall take no action prejudicing the rights and interests of the Corporation hereunder.

(i) Amendments of this contract and changes in the amounts or types of coverage or in the persons covered, as applied for or directed by applicant, shall be applicable only as to hospital admissions occurring on or after the effective date of such amendment or change.

PART VII — DEFINITIONS

(a) Corporation — The term "Corporation" shall mean the Hospital Service Corporation of Rhode Island, 31 Canal Street, Providence, Rhode Island.

(b) Applicant — The term "Applicant" shall mean any individual with whom the Corporation has entered into a subscription agreement.

(c) Subscriber — The term "Subscriber" shall include the applicant and each person listed on the application so long as such persons remain eligible for inclusion in accordance with the Corporation's Enrollment Regulations. Unmarried subscribers listed on the application will cease to be members at the end of the calendar year during which they attain age 19. A minor subscriber listed on the application who marries before the end of

PART VII — DEFINITIONS *continued*

the calendar year in which he or she attains age 19 will cease to be a subscriber on the first of the month following marriage. A minor subscriber whose membership ceases following marriage or attainment of age 19 as aforesaid, may enroll under his or her own membership by application to the Corporation in writing. A handicapped child, regardless of age, may be retained as a subscriber on the applicant's family membership provided a special supplemental application for such child has been filed with and accepted by the Corporation.

(d) Subscription Agreement — The term "Subscription Agreement" shall mean the agreement entered into between the Corporation and the applicant and shall consist of the application, including any supplemental application, and the appropriate Blue Cross Contract for Hospital Care then in force and filed with the State of Rhode Island Insurance Division of the Department of Business Regulation, the membership card evidencing the acceptance of the application and any amendments made under Part V (d) hereof.

(e) Applicant's Agent — The term "Applicant's Agent" shall mean any individual who, or firm, association or corporation which pays for applicant, in whole or in part, or which as agent for the applicant has agreed to collect and remit, in whole or in part, subscription charges payable under this agreement. Such applicant's agent shall not be construed to be the agent of the Corporation.

(f) Hospital — The term "Hospital" (except where the context otherwise requires) shall mean any institution listed as such by the American Hospital Association and approved by the Corporation, or any institution operated exclusively for the care as bed patients of medical and surgical cases involving acute illness or injury approved by the Corporation. It shall not include convalescent homes, rest homes, nursing homes, homes for the aged, school infirmaries, or private sanitaria.

(g) Member Hospital — The term "Member Hospital" shall mean any hospital in the State of Rhode Island (excluding hospitals operated by the State of Rhode Island) with which the Corporation has a participating member hospital contract for the rendering of hospitalization provided by the subscription agreement.

(h) Service-Benefit Hospital — The term "Service-Benefit Hospital" shall mean any hospital outside of the State of Rhode Island with which the Corporation has a contract for the rendering of hospitalization provided for by the subscription agreement.

(i) Non-Member Hospital — The term "Non-Member Hospital" shall mean any hospital with which the Corporation does not have a contract for the rendering of hospitalization provided for by the subscription agreement.

(j) Comprehensive Plan — The term "Comprehensive Plan" shall mean the plan in effect with any Group where the Corporation's appropriate Enrollment Regulations have been met, and where membership in such plan is indicated by the symbol "C", "F", or "J", on the subscriber's membership card.

THE MATERIAL BELOW IS FOR EXPLANATION ONLY AND IS NOT PART OF THIS CONTRACT.

Keep your Blue Cross Contract in a safe place, along with your other valuable papers.

Your Membership Number and daily hospital room allowance are shown on your membership card.

If you should have a question about your membership, or your benefits, you might want to refer to this contract. Or, call or write the Blue Cross office.

Our most important job is to provide you with the very best service possible.

How To Get Your Benefits

When you go to the hospital for care, be sure to have your membership card with you. It describes your hospital room plan and is your "credit card" for hospital care. Merely present your Blue Cross card at the hospital . . . and they'll do the rest. It's as simple as that.

Care Away From Home

Your membership card is recognized by over 6,000 Blue Cross member hospitals across the nation. If you need care away from home, merely present your Rhode Island Blue Cross card to the hospital. When you are discharged, your benefits will be credited to your bill, and you will be billed only for excess charges, if any.

Remember, if you have a question about your benefits or your membership, the best way to get accurate answers is to call or write Blue Cross.

PLEASE GIVE YOUR MEMBERSHIP NUMBER WHENEVER YOU CALL OR WRITE BLUE CROSS.

Hospital Service Corporation of Rhode Island
31 Canal Street, Providence, Rhode Island 02901
Telephone 831-7300

PHYSICIANS SERVICE
CONTRACT
for Surgical-Medical Care

Rhode Island Medical Society Physicians
Service
Providence, Rhode Island

A non-profit community service, incorporated under the laws of Rhode Island in 1949.

This contract is made between the Rhode Island Medical Society Physicians Service (hereinafter called the Corporation) and the Applicant named in the application to receive the benefits provided herein and whose name and identification number appear on the membership card furnished to said Applicant.

In consideration of the application and upon payment in advance of the subscription charges, the CORPORATION agrees to provide to said Applicant and each Subscriber, if any, listed on the application or re-classification thereof, the surgical-medical benefits according to the PHYSICIANS SERVICE PLAN described on the following pages, which is a part of this contract.

In Witness Whereof, the RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE has executed this contract.

RHODE ISLAND MEDICAL SOCIETY
PHYSICIANS SERVICE

By: Arnold Porter
President

Attest: George W Chaplin
Secretary

Countersigned: Arthur F. Hanley
Executive Director

Surgical-Medical Series 6 (7-1-65)

THE PHYSICIANS SERVICE PLAN
FOR
SURGICAL-MEDICAL CARE

PART I—PHYSICIANS SERVICE BENEFITS PROVIDED:

The Corporation will pay, except as provided in PART III below, for the following surgical and medical services when rendered by a physician entitled by law to perform such service to an eligible subscriber in good standing an amount equal to the fees actually charged to the subscriber up to the maximum amount specified under whichever of Plan A or Plan B coverage he is entitled to in the Schedule of Allowances (PART VIII), (or such other maximum amounts as may be shown on the subscriber's membership card) such payments to be made to the physician if he is a participating physician, and otherwise to the applicant:

(a) Surgical Services (other than those services described in PART III below) rendered by a physician of the subscriber's choice in a hospital, in a physician's office, or at home.

(b) Services of an assisting physician in connection with an operative procedure when the nature of such procedure is such that his services are necssary.

(c) Services of a physician-anesthetist if other than the surgeon or assisting physician.

(d) Maternity Services, (but not including pre-natal and post-natal care in the home or in the physician's office) rendered by a physician in connection with childbirth, including a surgical delivery such as Caesarean Section, if the patient and her husband have both been subscribers under the same subscription agreement for at least 7 continuous months prior to the operation. (The 7 months' waiting period is waived for subscribers under the Comprehensive Plan.)

(e) Medical Services (except as provided in PART III below) when rendered by a physician to a subscriber, only while a bed patient in a hospital for treatment of an acute illness or injury, and only if no surgical services are performed during the same continuous period of disability.

(f) X-ray and Electrocardiogram Services to the extent provided in PART VIII below.

(g) COVERAGE UNDER MORE THAN ONE AGREEMENT: A subscriber, entitled to benefits under more than one subscription agreement of the Corporation, shall be entitled to the aggregate of the credits provided under whichever of paragraphs (a) through (f) of PART I of the several agreements may be applicable, but not exceeding the physicians' charges for services rendered under those paragraphs, nor shall such additional coverage increase the duration of benefits specified in this agreement. A subscriber entitled to benefits under subscription agreements of the Corporation and of another Blue Shield plan shall be entitled to receive credits for all of the benefits provided by both plans, but not exceeding the physicians' charges for services rendered nor for benefits from the Corporation longer in duration than specified in this agreement. Substitution of subscription agreements under which a subscriber is entitled to benefits or termination of one agreement and entry into another agreement, shall not increase the duration of benefits specified in this agreement.

PART II—SERVICE BENEFIT PROVISIONS:

Participating physicians have agreed with the Corporation that their charges for services will not exceed the benefits provided in PART VIII (A, B, C, D, and E) provided the subscriber's rate of income does not at the time of disability exceed the limit of the appropriate ELIGIBLE INCOME GROUP shown below:

PLAN A	PLAN B	
$4,000.00	$6,000.00	— For subscriber who has enrolled one or more family members.
$2,800.00	$4,000.00	— For subscriber who has enrolled himself only.

For the purpose of determining income eligibility, a subscriber's income shall be deemed to be the combined annual income of subscriber and spouse.

Any subscriber who, except upon the order of his physician, occupies hospital accommodations in a private room thereby removes himself or herself from the eligible income group.

For any subscriber whose rate of income is in excess of that of the eligible income group, or who is entitled to receive benefits for the same or similar services from some other source, the benefits provided under this contract shall apply as an indemnity, and if the fee of the physician exceeds that amount, such charges shall be the liability of the subscriber.

PART III—BENEFITS NOT PROVIDED:

This agreement does NOT include:

(a) Payment for any Surgical or Medical Services not performed by a legally qualified physician or surgeon.

(b) Payment for any Surgical or Medical Services not specified in PART I or in the Schedule of Allowances (PART VIII), except as provided in (f) below.

(c) Payment for any Surgical or Medical Services (i) in connection with any personal injury (including any occupational disease or condition as defined in Workmen's Compensation laws) arising out of and in the course of employment, connected therewith and referable thereto, except in the case of a self employed person; or (ii) provided or paid for by the United States or any of its agencies; or (iii) to the extent that the cost of such Surgical or Medical Services may be recoverable by or on behalf of the subscriber in any action at law or in settlement of compromise of any claim against any party other than an insurer of the subscriber.

(d) Payment for Surgical or Medical Services for correction of cosmetic defects existing prior to the effective date of the subscription agreement. Where there is associated impairment of function, benefits may be provided, under the Comprehensive Plan only, for the remedy of such impairment, but the subscriber shall be personally responsible for charges attributable to correction of the cosmetic defect.

(e) Payment for Surgical or Medical Services for any condition, disease or injury which existed on or before the effective date of this agreement. (This paragraph (e) does not apply for services rendered after 7 months continuous membership nor at all under the Comprehensive Plan.)

(f) Payment for unlisted procedures except in amounts determined by the Corporation and consistent with those listed in the Schedule of Allowances, PART VIII.

(g) Payment to the physician for Surgical or Medical Services rendered by such physician employed or retained by a hospital, the employer or any other party, to provide without fee the services performed.

PART IV — CHANGES:

An applicant who does not include his spouse and/or children on his application may add such family members only on the anniversary of the effective date of his Direct Payment membership or of the Group of which he is a member, whichever is applicable. An applicant who later marries may, within 60 days of such marriage, add his spouse to his membership by application to the Corporation if a Direct Payment membership, or if a Group membership, by application to the person who remits payments for the Group; after 60 days he may add his spouse on the anniversary date as indicated above. An applicant who included his spouse and/or children may remove such family members from his membership only as of a date subsequent to the request for removal when subscription charges are payable.

PART V — TERMINATION AND REFUND:

(a) If a Direct Payment membership, this agreement shall continue in force until a default shall exist for 15 days in the payment of subscription charges, or until the effective date, during such period of default of any new agreement the applicant may enter into with the Corporation, in either of which cases this agreement shall automatically terminate. The Corporation may reinstate this agreement at its sole discretion, but only to cover any illness or injury first manifesting itself more than 15 days after reinstatement, except that such limitation will expire at the end of 7 months of continuous membership following reinstatement.

(b) An applicant subscriber holding a Direct Payment membership who joins a Group at his place of employment may continue to maintain his Direct Payment membership independently of his new Group membership provided he makes written request to the Corporation, prior to the effective date of his new Group membership, or indicates his intent in the space provided on the Group application card. In the absence of such request this agreement will automatically terminate on the effective date of the new Group membership. In such cases the applicant will be eligible for a refund of that portion of the Direct Payment subscription charges paid beyond the effective date of the new Group membership and any subsequent payment of Direct Payment subscription charges when due will be accepted as a request for reinstatement of the Direct Payment membership as of such due date. A change or transfer from Direct Payment membership to new Group membership will not adversely affect eligibility for benefits based on continuity of membership.

(c) If a Group membership, this agreement shall continue in force until a default shall exist for 30 days in the payment of subscription charges, or until the effective date, during such period of default, of any new agreement the applicant may enter into with the Corporation, in either of which cases this agreement shall automatically terminate. Any applicant who leaves his place of employment may join a Group at his new place of employment or enroll on a Direct Payment basis in accordance with the Enrollment Regulations of the Corporation.

(d) The Corporation reserves the right to terminate this agreement at any time upon giving 15 days prior written notice to the Applicant. It may also, upon like notice at any time and from time to time, amend this agreement or any portion thereof and redetermine and fix the amount of subscription charges as it may deem necessary; provided, however, that each such amendment or change of subscription charges shall be effective as to this agreement only upon the expiration of the term for which the subscription charges have been paid. Notice shall be deemed to have been given to each subscriber entitled to benefits hereunder when mailed to the applicant at his address which appears upon the records of the Corporation, or when mailed to the applicant's agent, or when published in a daily newspaper published in the State of Rhode Island. Payment of subscription charges after the giving of notice of an amendment or change in subscription charges shall constitute an acceptance thereof in behalf of all subscribers entitled to benefits hereunder.

(e) The Corporation shall be relieved of all liability to provide credits for Surgical or Medical Services after the date of termination, except that if such termination occurs while a subscriber is confined as a bed patient in a hospital such subscriber shall be entitled to benefits in accordance with this agreement during such hospital stay.

(f) In the event of termination of this agreement within 8 months prior to the birth of a child to any subscriber who would otherwise be entitled to maternity benefits specified in PART I (d) of this agreement and when such subscriber maintains continuous membership by entering into a new agreement with the Corporation, which is in effect at the time of the child's birth, shall be entitled to the maternity benefits under whichever of the agreements provides the greater benefits, but not to the benefits of both.

(g) An applicant who terminates his membership, other than as provided in PART V (b) above, may do so effective as of the last day of the month in which the Corporation receives applicant's written request to terminate. He shall be entitled to a refund of any prepaid subscription charges applicable to periods following such effective date of termination.

PART VI — GENERAL CONDITIONS:

(a) The effective date of this agreement shall be that indicated on the application on file with the Corporation. Benefits hereunder shall be payable with respect to Surgical or Medical Services rendered on and after, but not before, the effective date, provided, however, that benefits will not be available hereunder to any subscriber in the hospital on and prior to the effective date in the treatment of the particular condition causing such hospitalization.

(b) All claims hereunder must be filed with the Corporation within 60 days after the services shall have been rendered. The maximum amount payable by the Corporation to any and all parties in interest for any particular disability shall not exceed the maximum amount provided by the Schedule of Allowances, except as provided in PART I (f) and PART VIII A 10 . Such payment shall constitute a full and final discharge of all obligations of the Corporation for such benefits.

(c) This agreement is made upon the express condition that any physician or hospital is authorized to disclose to the Corporation any information regarding or acquired in connection with attendance, care or treatment of any subscriber hereunder, and that all provisions of law or professional ethics forbidding such disclosures are waived by or in behalf of each subscriber hereunder.

(d) The applicant agrees that the applicant's agent may make available to the Corporation for inspection any employment and other personnel records which have a bearing upon the eligibility of the Enrolled Group, the applicant or any subscriber.

(e) The benefits available hereunder may be extended by action of the Board of Directors of the Corporation, but no subscribers shall be entitled to share in any assets, reserves, or other funds or property now or hereafter owned, acquired, or accumulated by the Corporation.

(f) Nothing in this agreement is intended to affect the relationship between the subscriber and his physician. The Corporation is under no obligation to secure a physician for the subscriber, nor does it assume any liability arising out of the physician-patient relationship, and neither the Corporation nor any of its Directors or employees shall be liable for any act, omission, or neglect of any physician.

(g) No action or suit at law or in equity shall be commenced until 30 days after written notice of claim has been given by the subscriber to the Corporation, nor shall such action be brought at all later than one year after the services on which such claim is based shall have been rendered.

(h) Benefits of this agreement are personal to the subscriber and are not assignable, except under terms and conditions determined by the Corporation.

(i) In the event any Surgical or Medical Service or benefit is provided for, or any payment is made or credit extended to, a subscriber under this agreement, the Corporation shall be subrogated and shall succeed to the subscriber's right of recovery therefor against any person or organization, except insurers on policies of insurance issued to and in the name of the subscriber. The subscriber shall pay over to the Corporation all sums recovered by suit, settlement or otherwise, on account of such Surgical or Medical Service or benefit.

The subscriber shall take such action, furnish such information and assistance, and execute such assignments and other instruments as the Corporation may require to facilitate enforcement of its rights hereunder, and shall take no action prejudicing the rights and interests of the Corporation hereunder.

(j) Amendments of this contract and changes in the amounts or types of coverage or in the persons covered, as applied for or directed by applicant, shall be applicable only as to services listed in PART VIII which are rendered on and after the effective date of such amendment or change except for In-Hospital Medical Care (PART VIII (f)), which shall be only for admissions to a hospital on and after the effective date of such amendment or change.

PART VII — DEFINITIONS:

As used in this agreement:

(a) **Corporation** — The term "Corporation" shall mean the Rhode Island Medical Society Physicians Service.

(b) **Applicant** — The term "Applicant" shall mean any individual with whom the Corporation has entered into a subscription agreement.

(c) **Subscriber** — The term "Subscriber" shall include the applicant and each person listed on the application so long as such persons remain eligible for inclusion in accordance with the Corporation's Enrollment Regulations. Each newborn child shall become a subscriber entitled to all benefits of membership (i) when a major surgical procedure is performed on the child, (ii) when the mother or child is discharged from the hospital, or (iii) when the child has attained the age of 14 days, whichever event shall first occur. Unmarried subscribers listed on the application will cease to be members at the end of the calendar year during which they attain age 19. A minor subscriber listed on the application who marries before the end of the calendar year in which he or she attains age 19 will cease to be a subscriber on the first of the month following marriage. A minor subscriber whose membership ceases following marriage or attainment of age 19 as aforesaid, may transfer his or her membership to a Group at their place of employment or may make written request to the Corporation for a Direct Payment membership. A handicapped child, regardless of age may be retained as a subscriber on the applicant's family membership provided a special supplemental application for such child has been filed with and accepted by the Corporation.

(d) **Subscription Agreement** — The term "Subscription Agreement" shall mean the agreement entered into between the Corporation and the applicant and shall consist of the application, including any supplemental application, and the appropriate Physicians Service Contract for Surgical-Medical Benefits then in force and filed with the State of Rhode Island Insurance Division of the Department of Business Regulation, and the membership card evidencing the acceptance of the application and any amendments made under PART V (d) hereof.

(e) **Applicant's Agent** — The term "Applicant's Agent" shall mean any individual who, or firm, association or corporation which pays for applicant, in whole or in part, or which as agent for the applicant has agreed to collect and remit, in whole or in part, subscription charges payable under this agreement. Such applicant's agent shall not be construed to be the agent of the Corporation.

(f) **Hospital** — The term "Hospital" (except where the context otherwise requires) shall mean any institution listed as such by the American Hospital Association and approved by the Corporation, or any institution approved by the Corporation which is operated exclusively for the care as bed patients of medical and surgical cases involving acute illness or injury. It shall not include convalescent homes, rest homes, nursing homes, homes for the aged, school infirmaries, or private sanitaria.

(g) **Schedule of Allowances** — The term "Schedule of Allowances" shall mean the Schedule of Allowances specified in PART VIII.

(h) **Physician** — The term "Physician" shall mean any person duly licensed and registered to practice surgery and/or medicine under any of the following — Chapter 5-37, 5-36, 5-31 or 5-29 of the General Laws of Rhode Island, 1956, as amended, or under equivalent laws of other states and countries.

(i) **Participating Physician** — The term "Participating Physician" shall mean any physician who has signed an agreement with the Corporation for rendering care under the terms and conditions of this contract, and within the scope he may render under his license.

(j) **Comprehensive Plan** — The term "Comprehensive Plan" shall mean the plan in effect with any Group where the Corporation's appropriate Enrollment Regulations have been met, and where membership in such plan is indicated by the symbol "C", "F", or "J" within the membership number shown on the subscriber's membership card.

PART VIII — SCHEDULE OF ALLOWANCES:

1. The following abridged Schedules list some of the allowances provided under this Contract for Surgery, Assistance at Surgery, Administration of Anesthesia, Diagnostic Procedures, Oral Surgery, In-Hospital Medical Care, Maternity Care, Diagnostic X-ray, and Electrocardiograms.

A complete listing of the scheduled allowances for procedures contained in the various Schedules is available for inspection at the offices of the Corporation, the State of Rhode Island Insurance Division of the Department of Business Regulation, or at most physicians' offices in the State of Rhode Island.

2. The amounts of allowances listed are not intended to fix the charges for the services of the physician, except as provided in PART II, relating to "Service Benefit Provisions".

3. Payment for services not provided by this Contract, or (when not contrary to the terms of PART II, relating to "Service Benefit Provisions") of charges in excess of the Allowances provided by this Contract, are the sole responsibility of the subscriber.

A. SCHEDULE OF ALLOWANCES FOR SURGERY:

1. **Pre and Post-Operative Care:** The allowances for surgical procedures shall include pre and post-operative care in the hospital only.

2. **Maximum Surgical Liability:** The maximum total liability for surgery, with respect to all operations due to the same or related cause which are performed during a continuous period of disability shall be $277 under Plan A and $404 under Plan B, except as hereinafter provided.

3. **A Continuous Period of Disability:** Operations for the same or related cause which are not separated by 90 days shall be deemed to have been performed during "a continuous period of disability"

4. **Multiple Surgical Procedures Through the Same Incision:** When two or more surgical procedures are performed (usually) through the same incision, payment will be made only for the procedure calling for the highest allowance.

5. **Multiple Surgical Procedures Through Separate Incisions:** When two or more surgical procedures are performed through separate incisions and in remote operative fields, payment will be made per schedule for the procedure carrying the highest allowance and one-half of the scheduled allowance for the minor procedure(s).

6. **Bilateral Procedures,** in separate operative fields, will be allowed an additional 50% unless otherwise specified in the schedule.

7. **When two surgeons,** during any operative intervention, perform separate operations, a claim may be submitted by each surgeon, reporting the procedure performed and the circumstances involved. Individual consideration will be given to such claims.

8. **Diagnostic Procedures (D.P.),** when performed as independent procedures (I.P.) and asterisked (*) in the Schedule of Allowances, are not limited to the surgical maximums of $277 under Plan A and $404 under Plan B.

9. **Independent Procedures (I.P.):** Payment will be made for procedures so designated only when done alone or independently of another procedure.

10. **Individual Consideration (I.C.)** will be given to procedures in the schedule where a specific allowance is not indicated and the initials "I.C." appear. Consideration also will be given for a payment in excess of a specific allowance where unusual conditions require additonal surgical procedures. The Corporation reserves the right, in its sole discretion, to determine the amount of allowances, if any, to be paid. The generality of this provision is not limited by any of the foregoing provisions.

(Abridged Schedule)

ABDOMEN	PLAN A	PLAN B
Appendectomy (I.P.)	$103	$150
Removal of gall-bladder	154	225
Partial removal of stomach	206	300
Resection of small intestines, with anastomosis	166	242
Removal of part of colon	226	329
Closure of perforated ulcer intestine	134	196
GYNECOLOGY		
Dilatation and curettage	$ 34	$ 50
Hysterectomy, subtotal	134	196
Hysterectomy, total	172	250
Repair of cystocele (I.P.)	83	121
Removal of ovarian cyst (I.P.)	103	150

HERNIA

Inguinal or femoral, unilateral	$103	$150
Inguinal or femoral, bilateral	134	196
Umbilical (I.P.)	100	146
Diaphragmatic	200	292

PROCTOLOGY

Hemorrhoidectomy, internal	$ 72	$104
Drainage of ischiorectal abscess (I.P.)	26	38

BREAST

Mastectomy, simple	$ 83	$121
Mastectomy, radical	186	271
Excision of benign breast tumor, unilateral	43	63

EAR, NOSE AND THROAT

Tonsillectomy and adenoidectomy		
Under age 12	$ 40	$ 58
Age 12 or over	46	67
Removal of nasal polyps, unilateral	17	25
Mastoidectomy, radical	186	271
Antrum operation, radical	109	158
Bronchoscopy (I.P.)	40	58

THYROID

Thyroidectomy, subtotal	$152	$221
Excision of thyroglossal duct, cyst or sinus	106	154

UROLOGY

Removal of kidney	$180	$263
Removal of stone from kidney	174	254
Prostatecomy, perineal, subtotal	183	267
Excision of hydrocele, unilateral (I.P.)	60	88
Removal of stone from ureter by cystoscopy	60	88
Removal of stone from ureter by operative incision	154	225

NEURO-SURGERY

Drainage of brain abscess	$217	$317
Removal of brain tumor	277	404
Decompression, subtemporal	114	167
Sympathectomy, thoraco cervical, unilateral	132	192
Frontal lobotomy, bilateral	172	250
Avulsion of supraorbital nerve	29	42

OPHTHALMOLOGY

Cataract operation	$174	$254
Needling of lens	57	83
Removal of iris	103	150
Enucleation of eyeball, simple	106	154
Enucleation of eyeball, with non-movable implant	143	209

LUNGS AND PLEURA

Removal of lung, total or partial	$257	$375
Drainage of empyema, open	103	150

HEART AND BLOOD VESSELS

Suture of heart wound or injury	$220	$321
Operation on the heart valves	266	388
Varicose veins:		
High ligation and injection, unilateral	51	75
High ligation and injection, bilateral	77	113

MISCELLANEOUS

Pilonidal sinus or cyst, excision	$ 77	$113
Drainage of infected bursa	11	17

ORTHOPEDIC SURGERY

FRACTURES:

1. All fracture allowances include the initial and subsequent application and removal of casts or splints.

2. A single payment will be made for the treatment of any fracture. If an open reduction is performed within three weeks following a closed reduction, only the payment for the open reduction will be allowed.

3. Payment will be made only on the basis of a single fracture of a bone, regardless of whether multiple fractures of the same bone are present.

4. Payment for plaster casts (independent procedure) is limited to one, unless otherwise stated in the schedule. Allowance includes the application and removal of cast.

(Abridged Schedule)

	PLAN A	PLAN B
Clavicle, with reduction	$ 34	$ 50
Clavicle, open reduction	86	125
Humerus, shaft with reduction	72	104
Humerus, open reduction	126	183
Wrist (Colles) with reduction	51	75
Femur, neck, with reduction	103	150
Patella, open reduction	103	150
Ankle, Potts, with reduction	74	108
Ankle, Potts, open reduction	132	192
DISLOCATIONS:		
Hip, closed reduction	72	104
Hip, open reduction	160	234
Shoulder, closed reduction	34	50
Shoulder, open reduction	129	188
OPERATIONS:		
Excision of semilunar cartilage of knee	117	171
Plastic reconstruction of joint, with or without graft-hip	243	354
Elbow	172	250
AMPUTATIONS:		
Shoulder	172	250
Arm	86	125
Forearm	86	125
Finger	34	50

B. SCHEDULE OF ALLOWANCES FOR SURGICAL ASSISTANTS:

When a licensed physician assists a surgeon during an operation for which the "Schedule of Allowances for Surgery" provides a fee of $50 or more under Plan A or $75 or more under Plan B, then:

1. If the services of an assisting surgeon are necessary and,

2. If the assisting surgeon is a physician engaged in private practice and is not an employee of the Hospital,

this Contract shall provide an allowance for such assisting surgeon equal to 15% of the surgical fee allowance. Minimum payment under Plan A to be $10, and under Plan B $15.

C. SCHEDULE OF ALLOWANCES FOR ANESTHESIA:

1. Benefits for anesthesia service will be provided when administered by a licensed physician engaged in private practice other than the operating surgeon or his assistant.

2. Anesthesia services include all other services concurrently rendered by the anesthetist during the period of anesthesia.

3. There is no anesthesia allowance in connection with obstetrical vaginal delivery.

4. Allowances for anesthesia service shall be based on 20% of the surgical allowance with a $13 minimum payment under Plan A and a $20 minimum payment under Plan B.

D. SCHEDULE OF ALLOWANCES FOR DIAGNOSTIC PROCEDURES:

1. Diagnostic Procedures (D.P.) when performed as independent procedures (I.P.) and when designated in the "Schedule of Allowances for Surgery" as diagnostic, are payable in addition to the surgical maximums of $277 under Plan A and $404 under Plan B.

2. Excepting Paragraph 2, Subsection A of PART VIII, all other provisions of PART VIII apply to the Schedule of Allowances for Diagnostic Procedures.

(Abridged Schedule)

	PLAN A	PLAN B
Biopsy of breast	$ 29	$ 42
Bronchoscopy, diagnostic	40	58
Right heart catheterization	43	63
Biopsy of mouth	9	13
Esophagoscopy, diagnostic	40	58
Gastroscopy, diagnostic	40	58
Cystoscopy, diagnostic, initial	17	25
Encephalography	37	54
Ventriculography	60	88

E. SCHEDULE OF ALLOWANCES FOR ORAL SURGERY:

1. All provisions for surgery as contained in PART VIII, Subsection A apply to the Schedule of Allowances for Oral Surgery.

2. The Plan will not make payment for general dental services such as routine extractions, (including full mouth extractions) prosthesis, orthodontia, operative restorations, fillings, medical or surgical treatment of dental caries or gingivitis, or any dentistry other than provided in the Schedule of Allowances for Oral Surgery.

(Abridged Schedule)

	PLAN A	PLAN B
Drainage of alveolar abscess	$ 9	$ 13
Surgical removal of partially impacted mandibular tooth	34	50
Surgical removal of completely impacted mandibular tooth	40	58
Dental Root Resection	20	29
Surgical Excision of impacted maxillary tooth	23	33
Excision of Mandibular tori	40	58

F SCHEDULE OF ALLOWANCES FOR IN-HOSPITAL MEDICAL CARE:

This indemnity, in the form of a cash allowance, will be made for medical services rendered by a physician to a subscriber, only while a bed patient in a hospital for treatment of an acute illness or injury subject to the following:

1. No surgical services are performed during the same continuous period of disability, except as provided under "Concurrent Care".

2. Any admission to the same or any other hospital for the same or related cause, occurring within 90 days of the date of discharge of a previous admission for such cause, shall be considered to be the same admission.

3. In computing the number of days eligible for payment, the day of admission shall be counted but not the day of discharge.

Allowances In A General Hospital:

A subscriber who is a bed patient in a hospital classified as a General Hospital by the American Hospital Association, and/or acceptable as such to the Corporation shall be entitled to a payment as follows:

Plan A — $4 per day for 70 days up to a maximum of $280 for any one hospital admission.

Plan B — $5 per day for the first 14 days and $4 per day for the next 84 days, for a maximum payment of $406 for any one hospital admission.

Allowances In Any Other Hospital:

A subscriber who is a bed patient in any Other Hospital shall be entitled to a payment as follows:

Plan A — $4 per day for a maximum of 45 days in the aggregate in each calendar year.

Plan B — $5 per day for first 14 days and $4 per day from the 15th day through the 45th day for a maximum of 45 days in the aggregate in each calendar year.

Allowances for In-Hospital Medical Care in a General or Other Hospital will be as stated above or such other amount as shown on the membership card.

All charges for physicians' medical services which exceed the cash allowance shall be the obligation of the subscriber and not the Corporation.

In-Hospital Concurrent Care: Benefits for In-Hospital Medical Care shall not be provided in conjunction with any hospitalization involving surgical or obstetrical care except as follows:

1. Wherein the same condition, disease or ailment (other than maternity) is treated medically for a period of time prior to surgical treatment by other than the surgeon, allowances may be made up to but not including the day of surgery.

2. If (because of the necessity of supplementary skills) two licensed physicians concurrently treat a distinct and separate condition, disease, or ailment, one physician rendering medical care and the other physician surgical care, allowances may be made for the medical care upon the physician's written report explaining such services.

The Corporation will not pay for In-Hospital Medical Care which could be considered routine pre or post-operative care; or for such services as determining post-operative fluid or electrolyte balance, observation or reassurance of the patient, or stand-by services such as supervision of maintenance therapy for a chronic disease which is not in fact aggravated by the performance of surgery.

G. SCHEDULE OF INDEMNITY ALLOWANCES FOR X-RAY:

1. Payment will be made under Plan A and Plan B according to the Schedule of Allowances for Diagnostic X-ray, or in such other amount as may be shown on the subscriber's membership card, as an allowance toward the total charges for X-rays.

2. All charges for X-rays which exceed the allowances shall be the obligation of the subscriber and not the Corporation.

3. No allowances will be made for X-ray or radium therapy, X-ray in connection with routine procedures on admission to a hospital, X-rays as part of a routine physical examination, fluoroscopic services, screening miniature films, or dental X-rays (except in case of traumatic injury).

(Abridged Schedule)

	PLAN A	PLAN B
Skull	$7.50	$7.50
Mandible	7.50	7.50
Chest, PA & lateral	6.00	6.00
Pelvis, both hips	5.00	5.00
Spine, complete	17.50	17.50
Spine, thoracic	6.00	6.00
Clavicle	5.00	5.00
Wrist	2.50	2.50
Toe	2.50	2.50
Barium enema, w/contrast	12.50	12.50
G.I. Series, complete	27.50	27.50
Cystography	10.00	10.00

H. SCHEDULE OF INDEMNITY ALLOWANCES FOR MATERNITY:

1. A cash allowance of $60 under Plan A, or $75 under Plan B, or such amount as may be shoown on the subscriber's membership card, will be provided toward the services of all physicians, including a physician anesthetist, in connection with each vaginal obstetrical delivery.

2. All charges for services rendered by a physician for peri-natal care, and for delivery that exceeds the maximum total herein specified shall be the obligation of the subscriber and not the Corporation.

3. Maternity cases requiring additional surgical procedures, such as Caesarean Section, shall be entitled to the allowance in the "Schedule of Allowances for Surgery"

I. SCHEDULE OF INDEMNITY ALLOWANCES FOR ELECTROCARDIOGRAMS:

1. A cash allowance of $10 will be made under Plan A or Plan B for each electrocardiogram when rendered to a subscriber while a bed patient in a hospital after the first one in each hospital admission, the total payment for each admission not to exceed $50 or such other amount as may be shown on the subscriber's membership card.

2. Any admission to the same or any other hospital for the same or related cause occurring within 90 days of the date of discharge of a previous admission for such cause shall be considered to be the same admission.

3. All charges which exceed the allowance shall be the obligation of the subscriber and not the Corporation.

THE MATERIAL BELOW IS FOR EXPLANATION ONLY AND IS NOT PART OF THIS CONTRACT.

Keep your Physicians Service Contract in a safe place, along with your other valuable papers.

If you should have a question about your membership, or your benefits, you might want to refer to this contract. Or, call or write the Blue Cross-Physicians Service office.

Our most important job is to provide you with the very best service possible.

To Help You Determine Your Benefits

To determine your Physicians Service benefits, here's all you need do.

1. Refer to your **Membership Card.** This shows whether you have Plan A or Plan B, individual or family plan.
2. Then, read your contract. Parts I through VII describe the types of benefits provided, the conditions of your membership, and what is not covered.

   Part VIII contains a condensed listing of the Physicians Service Schedule of Allowances. A complete listing of the surgical procedures, and other benefits, is available at physicians' offices, at Rhode Island Physicians Service, and at the State Department of Business Regulation.

How To Get Your Benefits

When you receive services that are covered by your plan, simply show your membership card to the doctor. **He will then:**

1. **Ask you to complete a portion of the claim form** that he will send to Physicians Service for payment. In most cases the doctor will be paid directly, and a copy of the paid claim will be mailed to you.

OR

2. **Request Payment Directly From You** — if he is a non-participating doctor. In this case, merely send your itemized bill (that explains the service rendered), or the doctor's claim form to the Physicians Service Claims Department. The bill will be processed, and you will be paid directly.

PLEASE GIVE YOUR MEMBERSHIP NUMBER WHENEVER YOU CONTACT PHYSICIANS SERVICE.

Rhode Island Medical Society Physicians Service
31 Canal Street, Providence, Rhode Island 02901
Telephone 831-7300

YOUR

BLUE CROSS PHYSICIANS SERVICE

SUPPLEMENTAL

CONTRACT FOR

MAJOR MEDICAL

BENEFITS

Issued Jointly By

HOSPITAL SERVICE CORPORATION

OF RHODE ISLAND

RHODE ISLAND MEDICAL SOCIETY

PHYSICIANS SERVICE

Series 1 (Rev. 11/1/64)

TERMS AND CONDITIONS

Section I — Definitions

When used herein,

(a) "Basic Contracts" shall mean the Corporations' Contracts and any riders and endorsements thereto, excluding this rider, issued by the Corporations to the applicant.

(b) The terms "Applicant," "Subscriber," "Physician," and "Hospital," shall have the same meaning as in the Basic Contracts.

(c) "Retired Subscriber" shall include only an applicant and his or her spouse, provided that the applicant is a retired employee who is retained in the group coverage of an employer both for the Basic Contracts and this supplemental contract for Major Medical benefits. A child of such a retired subscriber shall be deemed to be a "subscriber" for purposes of this rider if such child is a "subscriber" under the Basic Contracts.

(d) "Employer" means any individual, firm, association or corporation which employed the applicant (other than a retired subscriber applicant) on a full-time basis (not less than 20 hours per week) at the time this rider was issued and has agreed with the Corporations, as agent for the applicant, including retired subscribers, to pay or collect and remit to the Corporations the subscription charges payable hereunder.

(e) "Covered Medical Expenses" means the reasonable and customary charges for necessary services and supplies of the types listed below in this paragraph I (e), for an illness, injury, or bodily malfunction, when rendered, prescribed or ordered for a subscriber or a retired subscriber by a physician, to the extent that such charges are within the limits hereinafter set forth and are not covered by Basic Contracts or specifically excluded under Section V below; such services and supplies rendered, prescribed or ordered for a subscriber or a retired subscriber in an emergency when a physician is not available will also be treated as covered medical expenses if they are such as might reasonably have been rendered, prescribed or ordered by a physician if available. The Corporations will determine whether a charge is reasonable and customary by comparing it with charges made for similar services or supplies provided under similar conditions to persons under like circumstances and the determination of the Corporations shall be final. As to surgical or anesthesia services, the term "reasonable and customary charges" shall, if such subscriber or retired subscriber is covered by and eligible for service benefits of a Plan A or Plan B Physicians Service contract, mean an amount not in excess of the amount provided in the Master Schedule of Indemnities of the Plan applicable to such subscriber or retired subscriber whether such services are rendered by a participating or non-participating physician. The following services and supplies, if within the terms of the first sentence of this paragraph I (e) are covered medical expenses, whether provided in or out of a hospital:

(1) Physicians' services, including but not limited to surgery, consultations and home, office and hospital visits.

(2) Routine and special hospital services in full if in ward or semi-private accommodations, and if in a private room, then in full except for so much of the hospital's charge for private room and board as is in excess of $28 per day (or such other amount as may be shown on the membership card); also included are all special charges for services while a patient in an Intensive Care unit of a hospital.

(3) Anesthetics and their administration.

(4) Oxygen and the rental or purchase, whichever costs less, of equipment for its administration.

(5) Cross matching, grouping and typing, processing and administration fees associated with blood transfusions; blood plasma and blood products, subject to the exclusion provided in Section V (16).

(6) Radiation therapy.

(7) Diagnostic examinations, including x-rays, laboratory, basal metabolism, electrocardiogram, electroencephalogram and radioisotope.

(8) Professional ambulance service locally to or from a hospital for in-patients, or for out-patients receiving accident care.

(9) Physical therapy rendered by a qualified professional physical therapist.

(10) Orthopedic braces (except corrective shoes), crutches, and prosthetic appliances such as artificial limbs and eyes, including their replacement, repair, or adjustment, subject to exclusions listed in Section V hereof.

(11) Rental or purchase, whichever costs less, of wheelchair and other durable equipment used for medical treatment exclusively.

(12) Drugs and medicines which by law require a written prescription.

(13) Services of private duty nurses as follows: In a hospital—services of a registered nurse or a licensed practical nurse. Outside a hospital—services of a registered nurse, or of a licensed practical nurse upon written certification by the attending physician that the services of a registered nurse were necessary but unobtainable.

(14) Dental services listed under Master Schedule of Indemnities of the Physicians Service Contract and other dental services, supplies, and appliances required as a result of accidental injury to natural teeth and/or facial fractures occurring while the subscriber or retired subscriber is covered under this rider.

Covered Medical Expenses shall be deemed to be incurred as of the date the service is rendered or the supplies furnished.

(f) "Benefit Period" with respect to a subscriber or retired subscriber means a period of twelve (12) consecutive months, the first such period commencing on the first day occurring after the effective date of this rider on which a charge is incurred for services or supplies of the type listed as Covered Medical Expenses under the immediately preceding subsection (e) of this Section I, even though such charge is covered in whole or in part by the Basic Contracts. The second and subsequent benefit periods shall commence on the first day on which such a charge is incurred after the termination of the preceding benefit period. The date on which services or supplies were furnished shall govern rather than the date of billing therefor.

Section II — Benefits Provided

(a) If a subscriber or retired subscriber, while covered hereunder shall incur, during any Benefit Period, Covered Medical Expenses in excess of

(1) the benefits, if any, covered under the Basic Contracts, plus

(2) the Deductible Amount, if any, applicable to the Basic Contracts, plus

(3) the Deductible Amount applicable to this rider (see Section III hereof),

such subscriber or retired subscriber shall be entitled to credits from the Corporations equal to eighty per cent (80%) of the amount of such excess expenses, or such other percentage as may be shown on the membership card, except that for Covered Medical Expenses incurred in connection with the necessary care and treatment of mental disorders provided in the outpatient department of a hospital or outside a hospital, such subscriber or retired subscriber shall be entitled to credits from the Corporations equal to fifty per cent (50%) of such excess expenses in either case subject to all other terms and conditions of this rider.

(b) For each subscriber, other than a retired subscriber (see Section II (c) below), the maximum credits for benefits from the Corporations under this rider during any Benefit Period shall be Ten Thousand Dollars ($10,000.00), or such other amount as may be shown on the membership card, and the maximum credits for benefits from the Corporations during the entire time such subscriber is covered under this rider shall be Twenty Thousand Dollars ($20,000.00) or such other amount as may be shown on the membership card, subject, however, to Section II (e) below.

(c) For each retired subscriber, the maximum credits for benefits from the Corporations under this rider during any Benefit Period shall be Two Thousand Five Hundred Dollars ($2,500.00) or such other amount as may be shown on the membership card, and the maximum credits for benefits from the Corporations during the entire time such retired subscriber is covered under this rider as a retired subscriber shall be Five Thousand Dollars ($5,000.00) or such other amount as may be shown on the membership card.

(d) A subscriber who, during a benefit period, has incurred expenses in excess of the applicable Deductible Amount before becoming a retired Subscriber shall, for the balance of that Benefit Period, be eligible to receive the maximum credits of a "Subscriber," and in subsequent Benefit Periods will be eligible to receive credits as a "Retired Subscriber" but in no event will be eligible to receive total benefit payments in excess of the "subscriber" maximum credit. A subscriber totally disabled before becoming a retired subscriber shall be eligible to receive the credits of a "totally disabled subscriber" as stated in Section VI (e) (2) of this rider.

(e) If at any time, a subscriber, other than a retired subscriber, shall have become entitled to credits for benefits totaling at least Two Thousand Dollars ($2,000.00) under this rider, the maximum liability of the Corporations, with respect to such subscriber during such subsequent time as such subscriber may be covered under this rider, may be restored to the additional amount of Twenty Thousand Dollars ($20,000.00), or such other amount as may be shown on the membership card, upon receipt by the Corporations of evidence of such subscriber's insurability reasonably satisfactory to and approved by the Corporations. Any such evidence of insurability must be furnished without expense to the Corporations. The Corporations reserve the right to examine such subscriber by their own physician at their own expense.

(f) It is intended that each subscriber or retired subscriber shall be entitled to benefits from the Corporations under only one major medical benefit expense rider during his or her lifetime, subject to adjustment as provided in Section VII (f) hereof in the case of termination of coverage under one employer and resumption of coverage under another. A subscriber or retired subscriber who would be entitled to benefits under more than one major medical benefit expense rider of the Corporations but for this Section II (f) may elect against which one of the riders he wishes the benefits to be charged, and if his coverage under one of the riders is terminated, he may continue to charge benefits against the other, but the aggregate of benefits shall not exceed the total of maximum benefits for each Benefit Period and other maximum benefits set forth in any one such rider. If the subscriber or retired subscriber is entitled to benefits under this rider and under any other plan or contract of insurance or prepayment of medical expenses other than the basic contracts, the Corporations shall be liable on a pro rata basis only, to provide credits only for such proportion of the charges for such benefits as the total of credits under this rider bears to the total of credits and payments for such benefits specified under this rider and all other coverages.

Section III — Deductible Amount

The deductible amount applicable to this rider shall be One Hundred Dollars ($100.00), or such other amount as may be shown on the membership card, of covered Medical Expenses for each subscriber or retired subscriber which amount shall be applied once in each benefit period. If a common accident occurs to two or more subscribers or retired subscribers covered by the same family contract, a single deductible amount shall be applicable to the Covered Medical Expenses of such subscribers attributable to such accident.

Section IV — Waiting Period

As to any condition, disease, or injury which existed on or before the effective date of this rider, covered medical expenses shall include only so much of the expense for such condition, disease, or injury as is incurred on account of services or supplies rendered or furnished to the subscriber or retired subscriber on or after the 91st day succeeding such effective date, provided that no credits for such expenses will be given in the case of a subscriber or retired subscriber who, on the effective date of this rider, is confined in a hospital, nursing home, at home, or elsewhere on account of such a condition, disease, or injury, until a thirty-one-day period after such effective date has elapsed in which there has been no such confinement.

Section V — Exclusions

No benefits shall be provided hereunder on account of

1. Services or supplies for any occupational condition, ailment or injury arising out of and in the course of gainful employment, connected therewith and referable thereto.
2. Services or supplies required for obstetrical delivery, normal prenatal and postnatal care, or any condition related to pregnancy, (except as to expenses incurred for Caesarean Delivery and the following Complications of Pregnancy during a period of hospital confinement of a subscriber or retired subscriber who has satisfied the waiting period, if any, of the Basic Contracts, and of this rider.

   Any pregnancy terminating before expiration of 26 weeks, ectopic pregnancy, miscarriage, or abortion.

   Placenta previa or placenta abruptio.

   Aggravation of a heart condition or diabetes.

   Nephritis or pyelitis of pregnancy.

   Hyperemesis gravidarum.

   Toxemia.

   Premature rupture of membranes.)
3. Physicians' visits for the routine care or examination of a newborn child, prior to his or her becoming a subscriber under the Basic Contracts.
4. Dental services other than those specified in Section I (e) (14) above.
5. Services or supplies required for cosmetic purposes unless related to an accidental injury occurring while the subscriber or retired subscriber is covered under this rider.
6. Eyeglasses, contact lenses, hearing aids, and examinations and fittings therefor.
7. Services or supplies rendered or furnished in a hospital operated by any agency of the United States government, or for which the subscriber or retired subscriber would be entitled to full or partial benefits under any municipal, state or federal law, ordinance or regulation if this rider were not in effect.
8. Services or supplies for or connected with routine or periodic physical examinations, screening examinations, immunization shots, removal of corns or calluses, or trimming of toenails.
9. Services and supplies for personal comfort, such as radio, television, telephone, newspapers, beauty and barber services or supplies, air conditioners, dehumidifiers, etc., whether or not ordered by a physician.
10. Services and supplies required as a result of war, declared or undeclared, or military action, occurring after the effective date of this rider.
11. Travel, whether or not prescribed by a physician.
12. Custodial care, rest cures, or care in convalescent or nursing homes or homes for the aged.
13. Services and supplies for which the subscriber or retired subscriber has no legal obligation to pay or for which no charge would be made if this rider were not in effect.
14. Services of a private duty nurse who is a member of the household of the subscriber or retired subscriber or his or her spouse, parent, child, brother or sister by blood, marriage or adoption.
15. Services and supplies not medically necessary for the diagnosis or treatment of an illness, injury or bodily malfunction.
16. Whole blood, red blood cells, and/or responsibility or penalty fees of blood banks.
17. Services or supplies not listed as "Covered Medical Expenses" in Section I (e).

Section VI — Termination and Amendment

Coverage under this rider shall terminate

(a) As to any subscriber or retired subscriber on the date he or she ceases to be such.

(b) At the expiration of the 30th day, if a default shall exist for thirty (30) days in the payment of the subscription charges for this rider.

(c) On the date to which subscription charges have been paid if the applicant, other than a retired applicant, ceases to be in the full time employment (not less than 20 hours per week) of the Employer who has paid or collected subscription charges payable hereunder.

(d) On the date when total credits due from the Corporations to the subscriber or retired subscriber shall equal the maximum liability during the entire time of coverage under Section II (b) or (c) above, unless the maximum is restored under Section II (e) above, but if the subscriber or retired subscriber exhausting such total credits is the applicant, coverage for other subscribers or retired subscribers listed on his application, if any, may be continued, subject to payment by the employer of subscription charges prescribed by the Corporations.

(e) The Corporations reserve the right to terminate this coverage, or to amend the same, as provided in the Basic Contracts.

The Corporations shall be relieved of all liability for any expenses incurred after the date of termination, except: (1) if a subscriber or retired subscriber is, on such date, confined as a bed patient in a hospital, such subscriber or retired subscriber shall be entitled to benefits hereunder for Covered Medical Expenses incurred (as a result of the accident, illness, or injury requiring such hospitalization) while in such hospital and for a period not to exceed thirty (30) days from the date of discharge from the hospital; (2) if a subscriber or retired subscriber is totally disabled on such date, such subscriber or retired subscriber shall be eligible to receive credits for Covered Medical Expenses incurred during the Benefit Period in which such termination date occurs and during the immediately succeeding Benefit Period, but only if the Covered Medical Expenses are incurred with respect to the accident, illness, or injury on account of which the subscriber or retired subscriber is totally disabled at such termination date, and only if such total disability is continuous to the date or dates on which such expenses are incurred.

Section VII — General Provisions

(a) The Corporations may pay any charges giving rise to credits due under this rider directly to the hospital, doctor, nurse or other renderer of service or furnisher of supplies hereunder or may make such payment to the applicant for himself and his dependent subscribers, or to the subscriber or retired subscriber.

(b) This rider is made upon the express condition that any hospital, physician, pharmacist, or other supplier of services and supplies is authorized to disclose to the Corporations any information regarding or acquired in connection with the attendance, care, or treatment of any subscriber or retired subscriber hereunder and that all provisions of law or professional ethics forbidding such disclosures are waived by or in behalf of each such subscriber or retired subscriber hereunder.

(c) The benefits of this rider are nonassignable.

(d) All claims hereunder must be filed in writing with the Corporations within sixty (60) days after the services have been rendered or the supplies furnished. No action or suit at law or in equity shall be commenced until thirty (30) days after written notice of claim has been given by the subscriber or retired subscriber to the Corporations, nor shall any action or suit be brought at all later than one (1) year after the services or supplies on which such claim is based shall have been rendered or furnished.

(e) This rider is invalid for any purpose whatsoever unless issued by the Corporations as an endorsement to Basic Contracts which are and remain in full force and effect.

(f) The Provisions hereof relating to maximum benefits, deductible amount, waiting period and other pertinent provisions shall be adjusted by the Corporations in their discretion in the case of a subscriber whose coverage under one employer may be terminated and resumed under another employer, but in no case shall such subscriber be entitled to greater benefits than he would have received hereunder if there had been no termination.

(g) All of the terms, conditions and definitions of said Basic Contracts not inconsistent with the terms and conditions of this rider shall apply to and be and become a part of this rider as fully and as completely as though specifically set forth herein; the provisions of the Basic Contracts relating to subrogation are expressly incorporated herein by reference.

HOSPITAL SERVICE CORPORATION
OF RHODE ISLAND
RHODE ISLAND MEDICAL SOCIETY
PHYSICIANS SERVICE

Subscriber's Supplemental
Contract for
Major Medical Expense
Benefit Rider

This Contract is made between HOSPITAL SERVICE CORPORATION OF RHODE ISLAND, THE RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE (hereinafter called the CORPORATIONS) and the Applicant named in the application to receive the benefits provided herein and whose name and identification number appear on the membership card furnished to said Applicant.

In Consideration of the application, and upon the payment in advance of the applicable additional subscription charges, the CORPORATIONS agree to provide to the Applicant and each Subscriber or Retired Subscriber, if any, listed on the application, and any supplemental application, the major medical expense benefits described in the following pages which are a part of this contract, subject to the terms and conditions therein.

The benefits provided by this Supplemental Contract shall be in addition to the benefits under Applicant's Contract with HOSPITAL SERVICE CORPORATION OF RHODE ISLAND for hospital care and with THE RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE for medical service, (herein called the CONTRACTS) and shall be available only to those persons entitled to the benefits of both such Contracts, and this rider shall constitute an endorsement to and amendment of said Contracts.

The plan and type of coverage for which the Applicant is enrolled for — hospital care — surgical-medical benefits — major medical expense — are shown on his identification card.

In Witness Whereof, the HOSPITAL SERVICE CORPORATION OF RHODE ISLAND and THE RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE have executed this Contract.

HOSPITAL SERVICE CORPORATION
OF RHODE ISLAND

Attest:
Secretary.

President

THE RHODE ISLAND MEDICAL SOCIETY
PHYSICIANS SERVICE

Attest:
Secretary George W. Chaplin

President

Countersigned: Arthur F. Hanley
Executive Director

THIS IS YOUR BLUE CROSS-PHYSICIANS SERVICE SUPPLEMENTAL CONTRACT FOR MAJOR MEDICAL BENEFITS.

Keep it in a safe place along with your basic Blue Cross and Physicians Service contracts, and your other valuable papers.

If you should have a question about your membership, or your benefits, you might want to refer to this contract. Or, call or write the Blue Cross-Physicians Service office.

Our most important job is to provide you with the very best service possible.

PLEASE GIVE YOUR IDENTIFICATION NUMBER WHEN YOU CALL OR WRITE BLUE CROSS-PHYSICIANS SERVICE.

BLUE CROSS

PHYSICIANS SERVICE

31 Canal Street
Providence, Rhode Island 02901

TE 1-7300

If any prior Certificate describing the same kind of group insurance has been issued to the Employee named herein such Certificate is void.

THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES

HEREBY CERTIFIES THAT,

Subject to the terms and conditions of Group policy No. 12703M
the Employee named on the back page of this
certificate, an Employee of

SCHOOL DISTRICT #11
Colorado Springs, Colorado

(Hereinafter called the Policyholder)

and his Dependents
(if he has elected to insure them)
are insured for Major Medical Expense Benefits as therein limited.

This Individual certificate is furnished in accordance with and subject to the terms of the said policy, which policy, and the application therefor, constitute the entire contract between the parties. This certificate is merely evidence of insurance provided under said policy, which insurance is effective only if the person concerned is eligible for insurance and becomes and remains insured in accordance with the provisions, terms and conditions of the said policy.

NOTE: The insurance described herein for Dependents is void and of no effect unless the insured Employee has eligible Dependents and such Dependents become insured in accordance with the terms set forth on the back page of this certificate.

(For additional provisions see subsequent pages hereof)

THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES

Health Care Plan
Group Major Medical Expense Certificate—Non-Occupational

(MM-610)

Printed in U. S. A.

PF 13745 Amended by PF 12473-13974-14364-15354-15590

(6309) C Colorado No. 2

DEFINITIONS

DEPENDENT. The term Dependent shall mean any of the following not eligible for insurance as an Employee of the Policyholder:

(a) An insured Employee's wife or husband not legally separated from the Employee.

(b) An insured Employee's unmarried child who has not attained the age of nineteen years.

(c) An insured Employee's unmarried child who is a full-time student, and has attained the age of nineteen years but has not attained the age of twenty-three years.

PERIOD OF HOSPITAL CONFINEMENT. A period of hospital confinement shall mean confinement in a legally constituted and operated hospital, (1) for any period when confinement is on account of accidental bodily injury and commences within 24 hours following such injury or for a surgical operation, or (2) for not less than 18 hours when confinement is for any other cause.

Any confinement which is not separated from any other confinement by (a) return to active employment in the case of an Employee, or (b) an interval of three months or more in the case of a Dependent, shall be considered as the same period of confinement as such other confinement if both are due to the same or related cause.

MAJOR MEDICAL EXPENSE BENEFITS

The Group policy provides that the benefits hereinafter set forth are payable for "covered charges" (defined below) incurred on account of a non-occupational accidental bodily injury or a non-occupational sickness, and are subject to the other provisions and limitations therein contained.

A. **BENEFITS.**

1. **AMOUNT OF BENEFITS.** When an Employee or Dependent has incurred covered charges while insured under the policy and such covered charges during a calendar year exceed the deductible amount (defined below) the Society shall pay an amount of benefits equal to 1. with respect to such excess covered charges made by a hospital for expenses incurred during a period of hospital confinement (a) with respect to the first $500 of such covered charges: (i) 100% of any such covered charges, excluding charges for private room and board, (ii) 80% of such covered charges for private room and board, (b) with respect to all other such covered charges during such confinement: 80%, and 2. with respect to such excess covered charges, including charges for pre-operative and post-operative care, made by a physician legally licensed to practice medicine and surgery for the performance of a surgical procedure, an amount determined in accordance with the provision entitled "Schedule of Operations," 3. with respect to all other such excess covered charges incurred during such calendar year: 80%, subject to a Maximum Amount of Benefits with respect to each insured person under the policy of $10,000.

2. **REINSTATEMENT OF MAXIMUM AMOUNT OF BENEFITS.** At any time after the payment of total benefits of $1,000 or more with respect to an insured person, such person may reestablish his Maximum Amount of Benefits by furnishing, without expense to the Society, evidence of his insurability satisfactory to the Society or, in the case of an Employee, by completing a continuous period of six months of active employment with the Policyholder. Effective as of the date of the Society's acceptance of such evidence or the date of the expiration of such six-month period, the amount of benefits previously paid with respect to such person shall not be considered in applying the Maximum Amount of Benefits. If the Maximum Amount of Benefits has been paid, the person shall become insured again as of the date of the Society's acceptance of such evidence or the date of the expiration of such six-month period.

B. **COVERED CHARGES.** "Covered charges" shall consist of the following charges for services, supplies, and treatment:

1. Charges made by a legally constituted and operated hospital for room and board and other services.
2. Charges made for diagnosis, treatment and surgery by a physician legally licensed to practice medicine and surgery.
3. Charges made by a Registered Nurse for private duty nursing service.
4. Charges for the following: local ambulance service, equipment, medication, appliances, x-ray services, laboratory tests, the use of radium and radioactive isotopes, oxygen, iron lung, physiotherapy, and similar services, supplies, and treatment.

The charges referred to shall in no event include any amount of such charges in excess of the regular and customary charges for the services, supplies and treatment furnished.

C. **DEDUCTIBLE AMOUNT.** The deductible amount for any calendar year shall be an amount equal to the sum of

1. the total amount of benefits provided (including the value of benefits provided on a service basis) with respect to covered charges incurred during such calendar year under any other group plan or plans toward the cost of which any employer makes contributions or payroll deductions or any labor union makes contributions, and
2. (except with respect to covered charges made by a legally constituted and operated hospital for expenses incurred during a period of confinement therein or fees of a physician legally licensed to practice medicine and surgery for the performance of a surgical procedure) a cash deductible of $50.

The deductible amount shall be applied separately to the amount of covered charges incurred during each calendar year by each person while insured under the policy, subject to the following exceptions:

(i) The cash deductible shall be reduced by any amount of covered charges incurred for the insured person involved during the last three months of the preceding calendar year which were applied toward the cash deductible for such preceding calendar year.

(ii) If two or more persons, while insured under the policy as members of the same family, incur covered charges on account of the same accident occurring while insured thereunder, a single cash deductible shall apply to the combined covered charges incurred by all such insured persons on account of the common accident during the calendar year in which such accident occurs and again during the following calendar year. Furthermore, any benefit paid that would not have been payable were it not for this provision, shall not be charged against the Maximum Amount of Benefits of the person involved.

If during any calendar year one of the insured persons incurs covered charges not related to the common accident such person may apply toward the cash deductible applicable to such charges any covered charges which he incurred during such calendar year and which were applied toward the common-accident cash deductible.

If greater benefits should be payable without application of exception (ii), the greater amount shall be paid.

LIMITATIONS APPLICABLE TO MAJOR MEDICAL EXPENSE BENEFITS

A. "Covered Charges" shall in no event be deemed to include expenses incurred for services, supplies, or treatment

1. unless such services, supplies, or treatment (including the entire period of hospital confinement) were prescribed as necessary by a physician legally licensed to practice medicine and surgery.
2. in any Federal hospital.
3. if they were incurred on account of
    a. dental work or treatment or dental x-rays, except as required because of accidental injury of sound, natural teeth occurring while insured under the Group policy,
    b. eye refractions, eyeglasses, or the fitting thereof,
    c. hearing aids or the fitting thereof,
    d. transportation, except for local ambulance service,
    e. war, declared or undeclared, including armed aggression,
    f. bodily injury arising out of and in the course of employment by any employer or disease with respect to which benefits are payable under any Workmen's Compensation or Occupational Disease Act or Law,
    g. health examinations not required in connection with treatment of sickness or injury.

B. No payment shall be made under the provisions of the Group policy entitled "Major Medical Expense Benefits" and "Extended Benefits" for any expenses incurred on account of pregnancy or resulting childbirth, abortion, or miscarriage, except that in the case of any complication arising out of such pregnancy, benefits shall be payable in accordance with said provisions, but with the following modifications:

1. Benefits shall be payable only for covered charges for which benefits are not payable under the provisions entitled "Maternity Benefits" and "Extended Maternity Benefits" and which are in excess of those which would have been incurred in the absence of complications, as determined by the Society.
2. If, in addition to a complication arising out of pregnancy there is a complication with respect to the newborn child, the covered charges therefor with respect to the child shall be combined with those of the mother for the purpose of the application of the Deductible Amount provision, and the deductible amount shall be calculated as though the combined charges were for one person; however, for the purpose of the Maximum Amount of Benefits set forth in the Benefits provision, the benefits paid shall be considered those of the one for whom the respective charges were made.
3. If a person is pregnant on termination of her Major Medical Expense Insurance and termination of insurance is for cause other than the termination of said Group policy or its amendment to terminate the Major Medical Expense Insurance of the class of which she is a member, the benefits set forth under this paragraph shall be applicable with respect to covered charges incurred within a period ending on December 31 of the calendar year following the calendar year in which such termination of insurance occurs.
4. If on termination of her Major Medical Expense Insurance a person is totally disabled because of pregnancy or a condition resulting therefrom so as to be continuously prevented from engaging in any occupation and performing all regular and customary duties and such termination of insurance is because of the termination of said Group policy or its amendment to terminate the Major Medical Expense Insurance of the class of which she is a member, the benefits set forth under this paragraph shall be applicable with respect to covered charges incurred during the continuance of such total disability but not beyond the date nine months following such termination of insurance.

C. "Covered Charges" shall in no event be deemed to include expenses incurred for services, supplies or treatment if they were incurred on account of injury or sickness which existed within three months prior to the effective date of a person's insurance or any condition related to said injury or sickness, except that this limitation shall not apply to any such expenses incurred after the date such person was continuously insured under said Group policy for a twelve month period.

D. Payment for psychiatric treatment shall be subject to the provisions and limitations of the policy and the following additional limitations:

1. "Covered Charges" incurred while not confined to a hospital shall not include any amount of professional fees in excess of $10.00 per visit and shall not in any event include the fees of any practitioner other than a physician legally licensed to practice medicine and surgery.
2. Benefits for "Covered Charges" incurred during a calendar year shall not exceed $500.

EXTENDED BENEFITS

If a person's Major Medical Expense Insurance under the Group policy terminates for cause other than payment of the Maximum Amount of Benefits, and if at the date of such termination the person is totally disabled by bodily injury or disease so as to be continuously prevented from engaging in any occupation and performing all regular and customary duties, then benefits shall be provided under said Group policy, as if insurance had not terminated, for covered charges incurred solely on account of such injury or disease during the uninterrupted continuance of such disability and within the following period: (a) in any case in which such termination of insurance is for cause other than the termination of said Group policy or its amendment to terminate the Major Medical Expense Insurance of the class of which such person is a member, within a period ending on the December 31 of the calendar year following the calendar year in which such termination of insurance occurs, (b) in any case in which such termination of insurance is because of the termination of said Group policy or its amendment to terminate the Major Medical Expense Insurance of the class of which such person is a member, within nine months following such termination of insurance.

MATERNITY BENEFITS

If a female Employee or a male Employee's wife, while insured under the policy, incurs covered charges on account of pregnancy or resulting childbirth, abortion, or miscarriage, benefits will be payable under this provision, subject to the other provisions and limitations of the policy, in an amount equal to the excess of such charges over the total amount of benefits provided (including the value of benefits provided on a service basis) with respect to such charges under any other group plan or plans toward the cost of which any employer makes contributions or payroll deductions or any labor union makes contributions, subject to a maximum payment for any one pregnancy under this provision of $200.

LIMITATIONS APPLICABLE TO MATERNITY BENEFITS

"Covered charges" shall in no event be deemed to include expenses incurred for services, supplies, or treatment

1. unless such services, supplies, or treatment (including the entire period of hospital confinement) were prescribed as necessary by a physician legally licensed to practice medicine and surgery.
2. in any Federal hospital.
3. if they were incurred on account of transportation except local ambulance service.
4. if they were incurred within nine months of the effective date of the female Employee's or the wife's insurance under the policy.

EXTENDED MATERNITY BENEFITS

If at the date of termination of a female Employee's or wife's insurance under the Group policy, such person is pregnant, benefits shall be payable under the provision entitled "Maternity Benefits" as if insurance had not terminated for any covered charges incurred on account of such pregnancy or resulting childbirth, abortion or miscarriage, during the first nine months following termination of insurance.

INDIVIDUAL TERMINATIONS

A. The insurance of any Employee under said Group policy shall cease automatically upon the occurrence of any one of the following events:

(1) the termination of the policy,

(2) the cessation of premium payments on account of such Employee's insurance thereunder,

(3) the termination of his employment in the classes of Employees insured thereunder,

(4) the payment of the Maximum Amount of Benefits with respect to such Employee.

Note: In case the Employee ceases active work due to sickness, injury, leave of absence or temporary lay-off the terms of the Group policy may provide for continuance of insurance for a limited period. The Employee should consult the Policyholder who is in a position to inform the Employee as to the terms of the policy in this respect.

B. The insurance under the Group policy of any Employee's Dependent shall cease automatically upon the occurrence of any one of the following events:

(1) the termination of the Employee's insurance under said Group policy, provided that when such termination results from

  (a) the payment of the Maximum Amount of Benefits with respect to the Employee, the insurance of his Dependents may be continued but not beyond the termination of his insurance in the classes of Employees insured thereunder except as provided in (b) below in the event of the Employee's death, or

  (b) the death of the Employee, the insurance may be continued but not beyond one year immediately following such death.

(2) the cessation of premium payments on account of the insurance of such Employee's Dependent,

(3) when he ceases to be a Dependent as defined, except as provided in B (1) above,

(4) the payment of the Maximum Amount of Benefits with respect to such Dependent.

PRIVILEGE ON TERMINATION OF INSURANCE

I. Upon termination of insurance due to termination of employment in the class or classes of Employees insured under the Group policy, the Employee may obtain from the Society, without furnishing evidence of insurability, an individual policy of insurance covering himself and his spouse and children insured under the Group policy, by making written application and the first premium payment therefor to the Society within thirty-one days after such termination of insurance. The form of the individual insurance policy, the coverage thereunder, and all other terms and conditions thereof shall be as provided by the rules of the Society for such individual policy at the time of such application. The individual policy, if issued, shall become effective upon the day following the date of termination of insurance under the Group policy.

II. If termination of employment in the class or classes of Employees insured under the Group policy is caused by the Employee's death, or if such termination is due to other cause and the Employee dies within thirty-one days thereafter, with respect to the insurance of his surviving spouse and children under the Group policy, his surviving spouse shall have the privilege of obtaining an individual policy of insurance on the same basis and subject to the conditions indicated in Section I hereof.

III. Where the insurance of a dependent child under the Group policy is terminated by reason of the age or marriage of the child, such child shall have the privilege of obtaining an individual policy of insurance on the basis and subject to the conditions indicated in Section I hereof.

SCHEDULE OF OPERATIONS

The amount of benefits for surgery referred to in the provision entitled "Amount of Benefits" shall be the greater of

1. 80% of such excess covered charges, and
2. the Basic Amount of Payment set forth below, with respect to such operation, but in no event shall such amount exceed the actual charges made by such physician.

	Basic Amount of Payment
ABDOMEN	
Appendectomy, freeing of adhesions or exploration of, or cutting into, the abdominal cavity	$150.00
Removal of gall bladder	225.00
Gastro-enterostomy	225.00
Resection of stomach, bowel or rectum	300.00
ABSCESSES (see Tumors)	
AMPUTATIONS	
Thigh, leg	187.50
Upper arm, forearm, entire hand or foot	150.00
Fingers or toes, each	22.50
BLOOD TRANSFUSION, each	37.50
BREAST.	
Removal of benign tumor or cyst requiring hospital confinement	75.00
Simple amputation	150.00
Radical amputation	225.00
CHEST.	
Complete thoracoplasty, transthoracic approach to stomach, diaphragm, esophagus; sympathectomy or laryngectomy	300.00
Removal of lung or portion of lung	300.00
Bronchoscopy, esophagoscopy	60.00
Induction of artificial pneumothorax, initial	37.50
refills each (not more than 12)	15.00
CYSTS. (see Tumors)	
DISLOCATION. Reduction of	
Hip, vertebra, ankle joint, elbow or knee joint (patella excepted)	52.50
Shoulder	37.50
Lower jaw, collar bone, wrist or patella	22.50

For dislocations requiring an open operation, the basic amount of payment is 2 times amount indicated.

EXCISION OR FIXATION BY CUTTING.	
Hip joint	225.00
Shoulder, knee joint, semilunar cartilage, elbow, wrist or ankle joint	150.00
Removal of diseased portion of bone, including curettage	75.00
EAR, NOSE OR THROAT.	
Fenestration, one or both sides	300.00
Mastoidectomy, one or both sides, simple	150.00
radical	225.00
Tonsillectomy, adenoidectomy, or both	45.00
Sinus operation by cutting (puncture of antrum excepted)	75.00

	Basic Amount of Payment
Submucous resection of nasal septum	$ 75.00
Tracheotomy	75.00
EYE	
Operation for detached retina	300.00
Cataract, removal of	225.00
Cutting into eyeball (through the cornea or sclera) or cutting operation on eye muscles	150.00
Pterygium (excision)	30.00
Removal of eyeball	112.50
FRACTURE. Treatment of	
Thigh, vertebra or vertebrae, pelvis, (coccyx excepted)	112.50
Leg, kneecap, upper arm, ankle (Potts)	75.00
Lower jaw, collar bone, shoulder blade, forearm, wrist (Colles), skull	37.50
Hand, foot	22.50
Fingers or toes, each	15.00
Nose	15.00
Rib or ribs, three or more	37.50
fewer than three	15.00

If compound fracture, basic amount of payment is one and one-half times amount indicated. If open operation, basic amount of payment is 2 times amount indicated. (Bone grafting or bone splicing considered as open operation; skeletal traction pin is not so considered.)

GENITO-URINARY TRACT	
Removal of, or cutting into, kidney	300.00
Fixation of kidney	225.00
Removal of tumors or stones in ureter or bladder	
by cutting operation	150.00
by endoscopic means	52.50
Cystoscopy	37.50
Removal of prostate by open operation	225.00
Removal of prostate by endoscopic means	150.00
Circumcision	22.50
Varicocele, hydrocele, orchectomy or epididymectomy,	
single	75.00
bilateral	112.50
Hysterectomy	225.00
Salpingectomy or oophorectomy, or both	150.00
Cervix amputation	75.00
Dilation and curettage (non-puerperal), cervix cauterization or conization, polypectomy, or any combination of these	37.50
Vaginal plastic, operation for cystocele or rectocele	112.50

	Basic Amount of Payment
GOITRE	
Removal of thyroid, subtotal	$225.00
Removal of adenoma or benign tumor of thyroid	150.00
HERNIA	
Single hernia	150.00
More than one hernia	187.50
JOINT	
Incision into, tapping excepted	37.50
LIGAMENTS AND TENDONS	
Cutting or transplant, single	75.00
multiple	112.50
Suturing of tendon, single	52.50
multiple	75.00
PARACENTESIS	
Tapping	22.50
PILONIDAL CYST OR SINUS	
Removal of	75.00
RECTUM	
Hemorrhoidectomy, external	37.50
internal or internal and external	75.00
Cutting operation for fissure	37.50
Cutting operation for thrombosed hemorrhoids	22.50
Cutting operation for fistula-in-ano,	
single	75.00
multiple	112.50
SKULL	
Cutting into cranial cavity (trephine excepted)	300.00
trephine	37.50
SPINE OR SPINAL CORD	
Operation for spinal cord tumor	300.00
Operation with removal of portion of vertebra or vertebrae (except coccyx, transverse or spinous process)	225.00
Removal of part or all of coccyx, or of transverse or spinous process	75.00
TUMORS	
Benign or superficial tumors and cysts or abscesses requiring hospital confinement	37.50
not requiring hospital confinement	15.00
Malignant tumors of face, lip or skin	75.00
VARICOSE VEINS	
Injection treatment, complete procedure,	
one or both legs	60.00
Cutting operation, complete procedure,	
one leg	75.00
both legs	112.50

The Basic Amount of Payment for any cutting operation not specified above shall be determined by the Society, on a basis consistent with the Basic Amounts of Payment appearing in the above schedule.

GENERAL PROVISIONS OF THE GROUP MAJOR MEDICAL EXPENSE POLICY APPLICABLE TO THIS CERTIFICATE

PROOF OF CLAIM. Written proof of claim covering the occurrence, character, and extent of the loss for which claim is made must be furnished to the Society at its Home Office in the City of New York within ninety days after the date of the loss with respect to which claim is made. Failure to furnish such proof within the time required by the policy shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof within the required time and that proof was given as soon as was reasonably possible.

The Society may require as part of the proof of claim, itemized bills of the hospital, physician, or other source of the services, supplies, and treatment, and a statement of the benefits provided therefor under any other group plan or plans toward the cost of which any employer makes contributions or payroll deductions or any labor union makes contributions.

PAYMENT OF CLAIMS. All benefits payable under the policy will be paid to the Employee immediately upon receipt of due written proof.

THE EQUITABLE LIFE
ASSURANCE SOCIETY
OF THE UNITED STATES
NEW YORK, N. Y.

Health Care Plan
Group Major
Medical Expense Certificate
(Non-Occupational)

Employee:

Certificate No.: 12703M-

Effective Date:

The insurance of any Dependent will be effective on the date as set forth above, or the date the Employee makes written election for such insurance, or the date he becomes a Dependent, whichever is the latest, except that

1. if the Employee elects to have his Dependents insured more than thirty-one days after the date of their eligibility, such insurance shall not become effective until the date of the completion of three months following the date of election, and
2. if on the date the insurance would otherwise become effective a Dependent is confined to a hospital by reason other than his birth therein, his insurance shall not become effective until the end of such confinement.

No. 2

EXAMINATIONS. The Society at its own expense shall have the right and opportunity to examine any person when and so often as it may reasonably require during the pendency of claim under the policy.

LEGAL PROCEEDINGS. No action at law or in equity shall be brought to recover under the policy prior to the expiration of sixty days after proof of claim has been furnished in accordance with the requirements of the policy, nor shall any such action be brought at all unless commenced within three years from the expiration of the time within which proof of claim is required by the provisions thereof.

TERMINATION AND CHANGE OF POLICY. On any premium due date the Policyholder may terminate the policy or, subject to the Society approval, may modify, amend or change the provisions, terms and conditions of the policy. No consent of any Employee or any other person referred to in the policy shall be required to effect termination of the policy or any modification, amendment, or change thereof.

Group 203-01

KAISER FOUNDATION HEALTH PLAN, INC.

A Nonprofit Corporation
Northern California Region

GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT

FACE SHEET

RECEIVED
MAY 4 1965
HEALTH PLAN
EXECUTIVE OFFICES

This Service Agreement, consisting of the attached Group Medical and Hospital Service Agreement and Benefit Schedules as supplemented by this Face Sheet, has been entered into between Kaiser Foundation Health Plan, Inc., a California non-profit corporation, and the group defined in Section 1-B below in order to provide eligible Subscribers and eligible Family Dependents electing to enroll hereunder with medical, surgical, hospital and related health care benefits as specified in the attached Benefit Schedules.

The following provisions supplement corresponding provisions of the attached Group Medical and Hospital Service Agreement.

Section 1. Definitions.

B. "Group" shall mean Sacramento County Supt. of Schools

Section 2. Eligibility and Enrollment.

A. (1). Subscribers must meet the following additional requirements: must be an active employee who is eligible for Group contribution toward Health Plan dues. Employees who are eligible for retirement after May 1, 1965 continue Group membership in retirement.

A. (2). Family Dependents must meet the following additional requirements: ~~Enrollment of any Subscriber's spouse over the age of 60 is subject to medical review.~~ Unmarried dependent children while registered on a full-time basis at a recognized educational institution may continue as Family Dependents until reaching age 24.

Section 3. Relations Among Parties Affected by Agreement.

No supplemental provisions.

Section 4. Rates and Payment.

A. The initial enrollment charge shall be none.

B. The periodic payment schedule is as follows:

Subscriber only	$ 8.35
Subscriber and one dependent	$ 16.30
Subscriber and two or more dependents	$ 23.10
Composite rate per Subscriber	$ -
Additional periodic payment:	
Subscriber age - or over	$ -
Dependent age - or over	$ -

Section 5. Services and Benefits.

A. Within the Northern California Service Area the Benefit Schedule or Schedules applicable under this Agreement are as follows:

For Subscribers, Benefit Schedule ONE B

For Dependents, Benefit Schedule ONE B

Section 6. Exclusions and Limitations.

B. (7). Benefits for pre-existing conditions are those specified in the following schedules:

For Subscribers, Benefit Schedule ONE B*

For Dependents, Benefit Schedule ONE B*

*Section H of Schedule One-B does not apply. In the case of any pre-existing condition, members are entitled to the same benefits under the same provisions as specified for conditions arising after the effective date of membership.

Section 7. Conversion and Transfer.

No supplemental provisions.

Section 8. Term and Termination.

No supplemental provisions.

Section 9. Amendment.

This Agreement, including the attached schedules and addenda, may be amended by Health Plan at any time with respect to any matter other than rates, by mutual agreement between Health Plan and Group. Health Plan may amend this Agreement with respect to any matter, including rates, effective as of any anniversary date by written notice to Group at least sixty (60) days prior to the anniversary date. All such amendments shall be deemed accepted by Group unless Group gives Health Plan written notice of non-acceptance at least thirty (30) days prior to the anniversary date, in which event this Agreement shall terminate in accordance with Section 8-D effective on the anniversary date.

Section 10. Miscellaneous Provisions.

E. The address of Group is 6011 Folsom Boulevard
Sacramento, California

Executed at Oakland, California, April 26, 1965, to take effect as of May 1, 1965, and continuing through November 30, 1965, and from year to year thereafter.

Accepted April 30, 1965

By

By

KAISER FOUNDATION HEALTH PLAN, INC.,
A California nonprofit corporation

By

Authorized Representative
Northern California Region

KAISER FOUNDATION HEALTH PLAN, INC.

A NONPROFIT CORPORATION
NORTHERN CALIFORNIA REGION

GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT

INTRODUCTION

Health Plan, in consideration of the periodic payments to be paid to Health Plan by Group and in consideration of the supplemental charges to be paid by or on behalf of Members, agrees to arrange Medical and Hospital Services and other benefits during the term of this Service Agreement, subject, however, to all terms and conditions of this Service Agreement and the attached Benefit Schedules.

Interpretation of Agreement. In order to provide the advantages of integrated medical and hospital facilities and of group medical practice, Health Plan operates on a direct-service rather than indemnity basis. The interpretation of this Agreement shall be guided by the direct-service nature of the Health Plan program.

1. DEFINITIONS

As used in this Medical and Hospital Service Agreement and all schedules or addenda hereto (except as otherwise expressly provided or made necessary by the context):

A. "Health Plan" shall mean Kaiser Foundation Health Plan, Inc., a nonprofit corporation organized for the primary purpose of arranging for Medical and Hospital Services; "Northern California Region" shall mean that division of Health Plan which operates in the San Francisco Bay Area.

B. "Group" is defined in Section 1-B of the Face Sheet.

C. "Subscriber" shall mean a person who meets all applicable eligibility requirements of Section 2 and enrolls hereunder, and for whom the prepayment required by Section 4 has been actually received by Health Plan.

D. "Family Dependent" shall mean any member of a Subscriber's family residing in the Subscriber's household who meets all applicable eligibility requirements of Section 2 and is enrolled hereunder and for whom the prepayment required by Section 4 has been actually received by Health Plan.

E. "Member" shall mean any Subscriber or Family Dependent.

F. "Medical Group" shall mean The Permanente Medical Group, a partnership of physicians.

G. "Physician" shall mean any doctor of medicine associated with or engaged by Medical Group; "Attending Physician" shall mean the Physician primarily responsible for the care of a Member with respect to any particular injury or illness.

H. "Hospital" shall mean any hospital in Health Plan's Northern California Region with which Health Plan maintains contractual arrangements for Hospital Services. A current list of such Hospitals may be obtained from any Health Plan office.

J. "Medical Office" shall mean any outpatient treatment facility in Health Plan's Northern California Region which is staffed by Medical Group. A current list of such Medical Offices may be obtained from any Health Plan office.

K. "Medical Services" shall (except as expressly limited or excluded by this Agreement) mean those professional services of physicians and surgeons, and para-medical personnel, including medical, surgical, diagnostic, therapeutic and preventive services, (i) which are generally and customarily provided in the San Francisco Bay Area, and (ii) which are performed, prescribed, or directed by Physicians.

L. "Hospital Services" shall (except as expressly limited or excluded by this Agreement) mean those services for registered bed patients which are (i) generally and customarily provided by acute general hospitals in the San Francisco Bay Area, and (ii) which are prescribed, directed or authorized by a Physician.

M. "Prevailing Rates" shall mean the rates generally prevailing in the San Francisco Bay Area for hospital, medical and related services.

N. "Health Plan Rates" shall mean the rates set forth in the Schedule of Supplemental Charges maintained at Hospitals and Medical Offices. Such rates are maintained at approximately 50% of Prevailing Rates for similar services. Said Schedule of Supplemental Charges may be revised without notice from time to time.

O. "Service Area" shall mean that geographical area within the nine San Francisco Bay Area counties (Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano and Sonoma) lying within a radius of thirty miles of any Hospital or Medical Office.

P. "House Call Service Area" shall mean that geographical area surrounding each Hospital and Medical Office within which house calls are rendered under this Agreement. Such areas may be revised without notice from time to time. A current definition of each House Call Service Area may be obtained at the Hospital or Medical Office upon which such House Call Service Area is based.

Q. "Pre-existing Condition" shall mean any injury, illness or condition existing, contracted or sustained prior to the commencement of a person's current term of uninterrupted Health Plan membership, and includes any recurrence or complication of any such injury, illness or condition. Congenital conditions are considered Pre-existing Conditions.

2. ELIGIBILITY AND ENROLLMENT

A. ELIGIBILITY OF INDIVIDUALS. Individuals will be accepted for enrollment hereunder only upon meeting all applicable requirements set forth below.

(1) Subscribers. To be eligible to enroll as a Subscriber a person must be either (a) an actual and bona fide member of Group or (b) entitled under the trust agreement, employment contract or other established standard of Group, on his own behalf and not by virtue of dependency status, to participate in medical and hospital care benefits arranged by Group.

Subscribers must meet the additional requirements specified in Section 2-A (1) of the Face Sheet.

(2) Family Dependents. To be eligible to enroll as a Family Dependent a person must be either (a) the spouse of the Subscriber or (b) a dependent unmarried child under the age of 19 of either the Subscriber or his spouse. Foster children entirely supported by the Subscriber and his spouse and legally adopted children of either, as well as natural children, are included. Newborn children will be treated as Family Dependents from birth if promptly enrolled by a parent.

Family Dependents must meet the additional requirements specified in Section 2-A (2) of the Face Sheet.

(3) Membership Previously Terminated. No person is eligible to enroll hereunder who has had Health Plan coverage terminated for cause under Section 8-B of this or any other Health Plan Medical and Hospital Service Agreement.

(4) Change of Group Eligibility Rules. The composition of Group and requirements determining eligibility for membership in Group and for participation in medical and hospital care benefits arranged by Group are considerations material to the execution of this Agreement by Health Plan; during the term of this Agreement no change in Group's eligibility or participation requirements shall be permitted to affect eligibility or enrollment under this Agreement in any manner deemed adverse by Health Plan unless such change is effected by mutual agreement with Health Plan.

B. ENROLLMENT. While enrollment is open for Group, Subscribers and Family Dependents who meet the requirements of Section 2-A may enroll hereunder by submitting complete applications on forms provided by Health Plan.

3. RELATIONS AMONG PARTIES AFFECTED BY AGREEMENT

The relationship between Health Plan and Medical Group and between Health Plan and Hospitals is an independent contract relationship; Physicians and Hospitals are not agents or employees of Health Plan, nor is Health Plan, nor any employee of Health Plan, an employee or agent of Hospitals or Medical Group.

Physicians maintain the physician-patient relationship with Members and are solely responsible to Members for all Medical Services. Hospitals maintain the hospital-patient relationship with Members and are solely responsible to Members for all Hospital Services.

Information from medical records of Members and information received by Physicians or Hospitals incident to the physician-patient or hospital-patient relationship is kept confidential, and, except for use incident to bona fide medical research and education or reasonably necessary in connection with the administration of this Agreement, is not disclosed without the consent of the Member.

Neither Group nor any Member is the agent or representative of Health Plan, and neither shall be liable for any acts or omissions of Health Plan, its agents or employees, or of Medical Group, any Physician, or Hospital, or any other person or organization with which Health Plan has made or hereafter shall make arrangements for the performance of services under this Agreement.

4. RATES AND PAYMENT

Payment for Health Plan coverage shall be made as follows:

A. INITIAL ENROLLMENT. Along with each initial application for enrollment the prospective Subscriber or Group shall remit to Health Plan the amount specified in Section 4-A of the Face Sheet to cover enrollment of the Subscriber and his Family Dependents.

B. PERIODIC PAYMENT SCHEDULE. Group shall remit to Health Plan on behalf of each Subscriber and his Family Dependents the amounts specified in Section 4-B of the Face Sheet for each month on or before the last day of the preceding month. Only Members for whom the stipulated payment is actually received by Health Plan shall be entitled to Medical and Hospital Services hereunder and then only for the period for which such payment is received.

If any payment required above is not timely paid by or on behalf of any Member, all rights of such Member hereunder shall terminate and may be reinstated only by renewed application and re-enrollment in accordance with all requirements of this Agreement.

C. SUPPLEMENTAL CHARGES. In addition, Members shall pay or arrange for payment of applicable supplemental charges as provided in the accompanying Schedules of Medical and Hospital Services, and in case of failure to do so, the Members' rights may be terminated on fifteen (15) days' notice and may be reinstated only by renewed application and re-enrollment in accordance with all requirements of this Agreement.

5. SERVICES AND BENEFITS

Subject to all terms and provisions of this Agreement, Members shall be entitled to receive services and other benefits as follows:

A. WITHIN NORTHERN CALIFORNIA SERVICE AREA. Within the defined Service Area in Northern California, Subscribers and Dependents are entitled to receive the services and other benefits specified in the benefit schedules described in Section 5-A of the Face Sheet, all as provided, prescribed, or directed by Physicians. Within this Area, Medical and Hospital Services are available only from Medical Group and Hospitals, and neither Health Plan, Hospitals nor Medical Group shall have any liability or obligation whatsoever on account of any service or benefit sought or received by any Member from any other doctor or hospital, or other person, institution or organization, unless prior special arrangements are made by a Physician and confirmed by written referral from Medical Group.

B. OUTSIDE NORTHERN CALIFORNIA SERVICE AREA. Members regularly residing in the Northern California Service Area while temporarily away from home and outside said Service Area may receive the additional benefits specified in Schedule TWO as therein defined and limited.

6. EXCLUSIONS AND LIMITATIONS

Health Plan operates on a direct-service basis to make available Medical and Hospital Services and related benefits in the manner which appears most advantageous to most Members. The general objective of Health Plan coverage is to provide necessary hospital and medical care:

Within the scope of the general public's willingness and ability to prepay;

Without duplicating care financed by other sources; and

Without devoting excessive resources to costly specialized facilities.

Moreover, Medical and Hospital Services available under this Agreement may be limited by the nature and capacity of Hospital and Medical Group facilities and personnel.

Accordingly, the following exclusions and limitations are established:

A. EXCLUSIONS. All services for conditions within any of the following classifications are excluded from the coverage of this Agreement:

(1) Psychiatric Conditions. Psychiatric care, including any treatment for insanity, mental illness or disorders; alcoholism, drug addiction.

(2) Self-Inflicted or Self-Induced Injuries. Conditions, and any complications thereof, resulting from attempts at suicide or other intentionally self-inflicted or self-induced injuries or illnesses.

(3) Employer or Governmental Responsibility. Illnesses, injuries or conditions covered by services or indemnification or reimbursement available either:

a. Pursuant to any federal, state, county or municipal workmen's compensation or employer's liability law or other legislation of similar purpose or import; or

b. From any federal, state, county, municipal or other governmental agency, including, in the case of service-connected disabilities, the Veteran's Administration.

In case of reasonable doubt as to whether a Member should receive benefits under this Agreement or from any such source, if the Member seeks diligently to establish his rights to benefits from such other source, services will be furnished under this Agreement; provided, however, that the value of such services, at Prevailing Rates, shall be recoverable by Health Plan or its nominee from such other source, or from the Member, if and to the extent it is determined that monetary benefits should have been provided by such other source.

(4) Custodial, Domiciliary, or Convalescent Care. Custodial care, domiciliary care, or convalescent care for which, in the judgment of the Attending Physician, the facilities and services of an acute general hospital and not medically required.

(5) Cosmetic Surgery and Dentistry. Conditions for which plastic surgery is indicated primarily for cosmetic purposes. Dental care and dental X-rays.

(6) Tuberculosis and Poliomyelitis. Tuberculosis after diagnosis and acute or contagious poliomyelitis after diagnosis and their complications.

B. LIMITATIONS. The rights of Members and obligations of Health Plan, Hospitals and Medical Group hereunder are subject to the following limitations:

(1) Major Disaster or Epidemic. In the event of any major disaster or epidemic, Physicians and Hospital shall render Medical and Hospital Services insofar as practical, according to their best judgment, within the limitations of such facilities and personnel as are then available, but neither Health Plan, Hospitals nor Medical Group shall have any liability or obligation for delay or failure to provide Medical and Hospital Services due to lack of available facilities or personnel if such lack is the result of such disaster or epidemic.

(2) Circumstances Beyond Health Plan's Control. In the event that, due to circumstances not reasonably within the control of Health Plan, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, disability of a significant part of Hospital or Medical Group personnel, or similar causes, the rendition of Medical or Hospital Services hereunder is delayed or rendered impractical, neither Health Plan, Hospitals, Medical Group nor any Physician shall have any liability or obligation on account of such delay or such failure to provide services.

(3) Corrective Appliances and Artificial Aids. Artificial aids, such as crutches or canes, and corrective appliances, such as braces, prosthetic devices, hearing aids, corrective lenses and eyeglasses, are not provided under this Agreement, but Health Plan will attempt to make arrangements whereby such aids and appliances may be obtained at reasonable rates; services necessary to determine the need therefor will be provided.

(4) Injuries Caused By Third Parties. In case of injuries caused by any act or omission of a third party, and complications incident thereto, services and other benefits requested hereunder will be furnished but will be charged at Prevailing Rates. However, the Member shall not be required to pay any amount in excess of the total amount collected on account of the injury.

(5) Contagious Diseases. Services are provided for contagious diseases other than tuberculosis and acute or contagious poliomyelitis, only in accordance with Section K of the benefit schedules described in Section 5-A.

(6) Rehabilitation. Neuromuscular rehabilitation and postpolio rehabilitation are excluded except as specifically provided in Section E-2 and Section L of the benefit schedules described in Section 5-A.

(7) Pre-existing Conditions. Services are provided for Pre-existing Conditions only in accordance with Section H of the benefit schedules described in Section 6-B (7) of the Face Sheet.

7. CONVERSION AND TRANSFER

A. CONVERSION TO INDIVIDUAL ENROLLMENT. If any person who has been a bona fide Member under this Agreement for at least ninety (90) days shall cease to be qualified to continue as a Member for any reason other than:

(1) Nonpayment of applicable charges or

(2) Termination of Membership rights pursuant to Section 8;

Then said person may, within thirty (30) days after termination of rights under this Agreement, convert his membership to such classification of Health Plan individual coverage as may be in effect at the time of his application for conversion.

B. TRANSFER OF RESIDENCE. Members who transfer their residence from the Northern California Region to any geographical area not served by Health Plan may, if they so desire, continue their Health Plan coverage by paying applicable charges. However, the only benefits provided outside of Health Plan service areas are those specified in Schedule TWO, Section B. For service benefits under Schedule ONE or Schedule TWO, Section A, the Member must return to the defined Service Area in Northern California or to another Health Plan service area identified in Schedule TWO, Section A.

Members who transfer their residence to another Health Plan Region must promptly apply to a Health Plan office in such Region for transfer of their membership. Acceptance of transfer applications is discretionary with Health Plan management in the Region to which transfer is sought; ordinarily, a person who has been a bona fide member in one Region for at least one year will be accepted for transfer.

No right to service benefits under Schedule TWO, Section A. shall exist in another Health Plan service area after a Member has lived in the vicinity of such service area more than 90 days, unless the Member, by prior application to Health Plan, demonstrates special circumstances under which a longer period is "temporary" and the Member's continuing status of temporary residence is confirmed in writing by Health Plan.

8. TERM AND TERMINATION

This agreement shall continue in effect for one year from the effective date hereof and from year to year thereafter, subject to:

A. TERMINATION ON NOTICE. Termination by either party by giving written notice to the other party at least thirty (30) days prior to the anniversary date.

B. INDIVIDUAL TERMINATION FOR CAUSE. In the event that Hospitals or Medical Group shall, after reasonable efforts to establish and maintain satisfactory hospital-patient or physician-patient relationships with any Member, be unable to do so, then the rights of such Member and other Members of his family under this Agreement may be terminated on not less than fifteen (15) days' written notice to Subscriber. At the effective date of such termination, prepayments received on account of such terminated Member or Members applicable to periods after the effective date of termination shall be refunded, and Health Plan shall have no further liability or responsibility under this Agreement.

C. TERMINATION BY HEALTH PLAN — HOSPITAL AND OBSTETRICAL BENEFITS. In the event that Health Plan terminates this Agreement pursuant to Section 8-A, any Member who is a registered bed patient in a Hospital at the effective date of termination shall receive these benefits: all benefits otherwise available hereunder to hospitalized patients, for the condition under treatment, during the remainder of that particular episode of hospitalization, until either (1) the expiration of such benefits, or (2) determination by the Attending Physician that hospitalization is no longer medically indicated, whichever shall first occur. In maternity cases under care at the effective date of termination Health Plan may either, at its election (a) continue obstetrical care only, through confinement and discharge, subject to payment of applicable supplemental charges, or (b) convert the Member from group to individual membership. Except as expressly provided in this Subsection, all rights to benefits shall cease as of the effective date of termination.

D. TERMINATION BY GROUP. In the event that Group terminates this Agreement pursuant to Section 8-A, then all rights to benefits shall cease as of the effective date of termination. Health Plan will cooperate with Group in attempting to work out equitable arrangements for continuing care of Members who are hospitalized at the termination date.

E. DISCONTINUANCE OF HEALTH PLAN OPERATIONS. If, due to circumstances beyond Health Plan's control, it shall become impractical, in the judgment of Health Plan's Board of Directors, to continue the operation of Health Plan within the Service Area, then Health Plan may terminate this Agreement at any time on thirty (30) days' written notice to Group, and neither Health Plan, Hospitals nor Medical Group shall have any further liability or responsibility by reason of or pursuant to this Agreement after the effective date of such termination.

9. AMENDMENT

This Agreement, including the attached schedules and addenda, may be amended by Health Plan pursuant to Section 9 of the Face Sheet.

10. MISCELLANEOUS PROVISIONS

A. ACCEPTANCE OF AGREEMENT. Group may accept this Agreement either by execution of the acceptance provided on the Face Sheet or by making payments to Health Plan pursuant to Section 4-B hereof, and such acceptance shall render all terms and provisions hereof binding on Health Plan and Group.

B. AGREEMENT BINDING ON MEMBERS. By this Agreement, Group makes Health Plan coverage available to persons who are eligible under Section 2; however, this Agreement shall be subject to amendment, modification or termination in accordance with any provision hereof or by mutual agreement between Health Plan and Group without the consent or concurrence of the Members. By electing medical and hospital coverage pursuant to this Agreement, or accepting benefits hereunder, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions and provisions hereof.

C. APPLICATIONS, STATEMENTS, ETC. Members or applicants for membership shall complete and submit to Health Plan such applications, medical review questionnaires, or other forms or statements as Health Plan may reasonably request; Members warrant that all information contained in such applications, questionnaires, forms or statements submitted to Health Plan incident to enrollment under this Agreement or the administration hereof shall be true, correct and complete, and all rights to benefits hereunder are subject to the condition that all such information shall be true, correct and complete.

D. IDENTIFICATION CARDS. Cards issued by Health Plan to Members pursuant to this Agreement are for identification only. Possession of a Health Plan identification card confers no right to services or other benefits under this Agreement. To be entitled to such services or benefits the holder of the card must, in fact, be a Member on whose behalf all applicable charges under this Agreement have actually been paid. Any person receiving services or other benefits to which he is not then entitled pursuant to the provisions of this Agreement shall be chargeable therefor at Prevailing Rates. If any Member permits the use of his Health Plan identification card by any other person, such card may be retained by Health Plan, and all rights of such Member pursuant to this Agreement shall be immediately terminable at the will of Health Plan.

E. NOTICES. Any notice under this Agreement may be given by United States Mail, postage prepaid, addressed as follows:

If to Health Plan:	Kaiser Foundation Health Plan, Inc. P.O. Box 116 Oakland, California 94604
If to a Member:	To the latest address provided for the Member on enrollment or change of address forms actually delivered to Health Plan.
If to Group:	To the address indicated in Section 10-E of the Face Sheet.

SCHEDULE TWO—BENEFITS FOR SUBSCRIBERS AND FAMILY DEPENDENTS OUTSIDE THE NORTHERN CALIFORNIA SERVICE AREA

This Schedule TWO supplements Schedule ONE and specifies the benefits available to Health Plan Members outside the Northern California Service Area.

These benefits are added to assist a Member who sustains accidental injury or becomes ill while temporarily away from his regular residence and from the Health Plan Service Area in Northern California. Accordingly, such benefits are limited to emergencies or other circumstances in which care is required immediately and unexpectedly; elective care or care required as a result of circumstances which could reasonably have been foreseen prior to departure from the Northern California Region is not covered.

A. SERVICE BENEFITS IN OTHER HEALTH PLAN SERVICE AREAS

Health Plan, either directly or through an affiliated corporation, conducts direct-service hospital and medical care programs in the Greater Los Angeles Area in California, on the Island of Oahu, Hawaii, and in Portland, Oregon and vicinity. Members regularly residing in the Northern California Region, while temporarily in another Health Plan service area, may receive hospital and medical services for emergency or other non-elective medical care requirements. To obtain such services Members must apply to a hospital or medical office, within such service area, which is covered by a contractual arrangement maintained by Health Plan for hospital or medical services and must pay applicable supplemental charges.

Services and supplemental charges shall be those prevailing in such service area for the Health Plan coverage generally provided within the service area which is most nearly comparable to the Member's coverage in the Northern California Region.

A description of such other service areas and a list of contracting hospital and medical office faclities located therein may be obtained at any Health Plan office in the Northern California Region upon request.

B. ADDITIONAL BENEFITS OUTSIDE THE NORTHERN CALIFORNIA SERVICE AREA

Subject to all the terms and conditions of the foregoing Service Agreement as modified and supplemented by this Schedule TWO, a Member is entitled to monetary benefits as provided in, and subject to the limitations of, this Section B.

1. Accidental Injury Outside Northern California Service Area. If a Member, while outside the Northern California Service Area, is accidentally injured and receives emergency treatment, Health Plan shall, subject to the limitations hereafter set forth, pay such Member up to an aggregate maximum of $500.00 on account of expenses actually incurred by such Member for:

a. emergency medical services;
b. emergency hospital services;
c. emergency ambulance service.

2. Emergency Illness Outside Northern California Service Area. If a Member becomes ill and requires emergency hospitalization while temporarily more than thirty miles from his regular place of residence and outside the Northern California Service Area, Health Plan shall, subject to the limitations hereafter set forth, pay such Member up to an aggregate maximum of $500.00 on account of expenses actually incurred by such Member for:

a. hospital services received as a registered bed patient in a general hospital;
b. medical services received as a registered bed patient in a general hospital;
c. emergency ambulance service.

Obstetrical Cases. Payment as outlined above will be made on account of emergency hospitalization required as a result of complications of pregnancy but not for normal delivery. Any unpaid portion of the supplemental charge specified in Schedule ONE, Section J, will be offset against amounts otherwise payable hereunder.

3. Continuing or Follow-up Treatment. Monetary payment on account of accidental injury or emergency illness is limited to emergency care required before the Member can, without medically harmful or injurious consequences, return to the Northern California Service Area or a Hospital or Medical Office in the nearest Service Area. Benefits for continuing or follow-up treatment are provided only at an appropriate Hospital or Medical Office in the nearest Service Area. If the Member obtains prior approval from Health Plan or a Physician in the nearest Service Area, a portion of the $500.00 allowance may be applied toward the cost of necessary ambulance service or other special transportation arrangements medically required to transport the Member to such Service Area for continuing or follow-up treatment.

4. Notification and Claims. Any Member having an emergency illness within the scope of Section B-2 shall notify a Northern California Health Plan office within forty-eight (48) hours after care is commenced.

No claim pursuant to this Section B shall be allowed unless a complete application for payment, on forms to be provided by Health Plan, is filed with a Health Plan office in the Northern California Region within sixty (60) days after the date of the first service for which payment is requested.

KAISER FOUNDATION HEALTH PLAN, INC.

NORTHERN CALIFORNIA REGION

SCHEDULE ONE-B MEDICAL AND HOSPITAL SERVICES
GROUP MEMBERSHIP, B COVERAGE

Subject to all terms, conditions and definitions in the foregoing Service Agreement, Members holding "B" coverage are entitled to receive the Medical and Hospital Services and other benefits set forth in this Schedule, upon payment of specified supplemental charges. These services and benefits are available only in the Northern California Service Area and only if and to the extent that they are (1) provided, prescribed or directed by a Physician, and (2) requested and, except for house calls pursuant to Section C, contagious disease benefits pursuant to Section K, and special benefits under Section M, received at a Hospital or Medical Office, all as defined in Section 1 of the Service Agreement.

For services and other benefits available outside the Northern California Service Area, see Schedule TWO.

A. MEDICAL CARE IN HOSPITAL AND OFFICE

1. CARE WHILE HOSPITALIZED. All services of Physicians and para-medical personnel as requested or directed by the Attending Physician, including operations, other surgical procedures, anesthesia, consultation with and treatment by specialists, laboratory and X-ray services as specified in Section D, and physical therapy as specified in Section E-1, are provided without charge while the Member is admitted to a Hospital as a registered bed patient.

2. CARE IN MEDICAL OFFICES OR EMERGENCY DEPARTMENTS.

a. Diagnosis and Treatment. All services of Physicians and para-medical personnel, as requested or directed by the Attending Physician, including surgical procedures, eye examinations for glasses, and consultation with and treatment by specialists, are provided at Medical Offices and Hospital emergency departments upon payment of a $1.00 registration charge per visit.

b. Preventive Services. In addition to diagnosis and treatment, Physicians' services for health maintenance, including physical check-ups and other preventive medical services, are provided upon payment of a $1.00 registration charge per visit. X-ray and laboratory examinations in conjunction with physical check-ups are provided pursuant to Section D.

Physical examinations required for obtaining or continuing employment or governmental licensing are not provided under Health Plan coverage.

B. HOSPITAL CARE.

For each injury or illness requiring hospitalization, including its recurrences and complications, 111 days of prescribed hospital care will be provided during each calendar year without charge. Hospital care includes room and board and general nursing care while the patient is admitted to the Hospital as a registered bed patient, and the following additional facilities, services and supplies as prescribed: use of operating room, private room, intensive care room and related hospital services; special diet, special-duty nursing, and medications and supplies as specified in Section F. Prescribed blood transfusions are provided without charge if blood is replaced at a Medical Group Blood Bank. If blood is replaced at any other blood bank, the Member is responsible for the applicable processing charge. Prevailing Rates will be charged if blood is not replaced. (A blood transfusion program is available to satisfy blood replacement obligations for Members desiring to make periodic blood contributions.)

C. HOUSE CALLS FOR EMERGENCIES OR ACUTE CONDITIONS.

All necessary house calls by Physicians for emergencies or acute conditions, and by visiting nurses when prescribed by a Physician, are provided within House Call Service Areas. For Physicians' house calls, payment in accordance with the following schedule is required:

Calls requested or made between 9 A.M. and 5 P.M.	$3.50 per call
Calls requested and made between 5 P.M. and 9 A.M.	$5.00 per call

An additional charge of $2.00 will be made for each additional Member who requires attention at the same household.

No charge is made for prescribed calls by visiting nurses.

If, in the Physician's judgment, more than two house calls are required during a particular episode of treatment on account of an emergency or acute condition, no further payment for house calls is required after the second house call.

D. X-RAY AND LABORATORY.

All prescribed X-ray and laboratory tests and services, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, metabolism, blood and urine and other laboratory tests, and diagnostic clinical isotope services, are provided without charge.

E. PHYSICAL THERAPY AND NEUROMUSCULAR REHABILITATION.

1. PHYSICAL THERAPY. Prescribed physical therapy will be provided upon payment of a $1.00 registration charge per visit. Physical therapy prescribed hereunder is limited to conditions which, in the judgment of the Attending Physician, are subject to significant improvement through relatively short-term therapy.

2. NEUROMUSCULAR REHABILITATION. More extensive specialized physical medicine and rehabilitation services, including physical therapy, provided at the Kaiser Foundation Rehabilitation Center in Vallejo, are available to Members at Health Plan Rates if the Attending Physician and the Kaiser Foundation Rehabilitation Center medical staff, after consultation, are of the opinion that the Member is apt to derive substantial benefits from a course of treatment of limited duration at the Rehabilitation Center. Hospitalization at the Kaiser Foundation Rehabilitation Center primarily for purposes of Neuromuscular Rehabilitation will be provided at Health Plan Rates.

F. PRESCRIBED MEDICATIONS.

A reasonable charge is made for medications, for injectables, for radioactive materials used for therapeutic purposes, for allergy test and treatment materials, and for supplies furnished to outpatients at Medical Offices, at Hospital emergency departments, or on house calls. A moderate charge may be made for administration of medications supplied by the patient.

During the 111-day period of prepaid hospitalization specified in Section B of this Schedule, all prescribed medications, injectables, radioactive materials used for therapeutic purposes, allergy materials and supplies are provided without charge.

Prescribed dressings and casts are provided without charge to Members at Hospitals, Medical Offices or on House Calls.

G. EMERGENCY AMBULANCE SERVICE.

Necessary ambulance service will be provided without charge within the Service Area if such service is ordered or approved by a Physician.

H. PRE-EXISTING CONDITIONS.

In the case of any Pre-existing Condition, Members are entitled to the same benefits upon the same conditions as are otherwise specified in this Schedule, subject, however, to the following provisions:

1. **NO ADDITIONAL PAYMENT.** Services of Physicians and paramedical personnel as specified in Sections A and C are furnished on payment of supplemental charges as provided in said Sections.

2. **HEALTH PLAN RATES.** All other benefits listed in Sections B through E except prescribed special-duty nursing and blood transfusions are provided upon payment of Health Plan Rates. Prescribed items as specified in Section F are provided at reasonable rates to both outpatients and hospitalized patients.

3. **PREVAILING RATES.** Special-duty nursing is provided at Prevailing Rates.

4. **BLOOD TRANSFUSIONS.** Prescribed blood transfusions are provided on the same basis and subject to the same charges as specified in Section B.

J. OBSTETRICAL CARE.

Full obstetrical care, after pregnancy is confirmed, including all applicable benefits set forth above, is provided upon payment of $60.00 if confinement is due after ten months' continuous membership, or upon payment of $140.00 if confinement is due before ten months' continuous membership. The supplemental charges specified in Section A of this Schedule will not be made for obstetrical care.

Obstetrical care includes the following services for the mother before and during confinement and during the post partum period: Hospital care, including use of delivery room; all services of Physicians including operations and special procedures such as Caesarean sections if necessary; anesthesia; medications, including injectables; X-ray and laboratory services as required for conditions relating to pregnancy.

Outpatient medications, including injectables, are subject to a reasonable charge.

Care for the newborn child is provided during the mother's confinement.

INTERRUPTED PREGNANCY. If care is required for interrupted pregnancy, Prevailing Rates shall be charged for all services rendered, but payment required hereunder shall not exceed two-thirds of the payment above specified for full obstetrical care.

INFERTILITY STUDIES. If requested by a Member, an infertility study series will be conducted under the direction of a Physician upon payment of a reasonable charge for the tests.

K. CONTAGIOUS DISEASES.

Diagnostic services and house calls are provided for contagious diseases; however, house calls are not provided for tuberculosis or acute or contagious poliomyelitis after diagnosis. Hospitalization will be provided if a Member is hospitalized at the direction of a Physician for treatment of a contagious disease in a Hospital.

In the case of contagious diseases, other than tuberculosis or acute or contagious poliomyelitis, for which isolation facilities or techniques are either required by Public Health authorities or medically recommended, and which, in the judgment of the Attending Physician, require hospital care, a Member, who is admitted at the direction of his Attending Physician to a hospital which does not contract with Health Plan, for treatment of such a contagious disease, will be reimbursed up to an aggregate maximum of $300.00 on account of expenses actually incurred by such Member for hospital and medical services. A current list of such contagious diseases may be obtained from any Health Plan office upon request.

A portion of the $300.00 allowance may be applied toward the cost of necessary ambulance service to a hospital which does not contract with Health Plan if such service is ordered by a Physician.

All benefits for treatment of contagious diseases are subject to all the terms and conditions contained in this Benefit Schedule, including supplemental charges.

L. POST-POLIO REHABILITATIVE CARE.

If ordered by the Attending Physician, post-polio rehabilitation, following the contagious and acute stage, provided at the Kaiser Foundation Rehabilitation Center in Vallejo, including hospitalization, if necessary, and incidental Hospital and Medical Services as medically indicated, is furnished to Members without charge under these circumstances:

1. This benefit is limited to persons who (a) contracted poliomyelitis after March 31, 1954, (b) were Members prior to contracting poliomyelitis, and (c) have maintained continuous membership.

2. Rehabilitative care under this benefit is limited to the lesser of (a) a maximum period of one year or (b) a maximum value of $2,500 computed at Prevailing Rates for all services rendered.

M. PAYMENT IN LIEU OF SERVICE BENEFITS.

If, in the professional judgment of Medical Group, a Member requires Medical or Hospital Services included in the coverage of this Service Agreement which require skills not available within Medical Group or facilities not available in Hospitals and Medical Offices, and Medical Group determines that it would be in the best interests of the Member to obtain care from another source in the community, then, upon written referral by Medical Group, payment, in lieu of service benefits hereunder, will be made for prescribed services within the coverage of this Agreement subject to the following limits: Medical Services will be reimbursed under the California Medical Association's Relative Value Study, Third Edition, using a unit value of $4.00. Charges for Hospital Services will be reimbursed in accordance with the benefits to which the Member would be entitled at a contracting Hospital.

AMENDMENT I TO

GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT

Subsection O of Section 1. DEFINITIONS, is amended as follows.

1. DEFINITIONS

O. "Service Area" shall mean that geographical area within the sixteen Northern California counties (Alameda, Amador, Contra Costa, El Dorado, Marin, Napa, Placer, Sacramento, San Francisco, San Mateo, Santa Clara, Solano, Sonoma, Sutter, Yolo and Yuba) lying within a radius of thirty miles of any Hospital or Medical Office.

May 1, 1965

AMENDMENT II TO

Effective July 1, 1965, in the case of any Pre-Existing Condition, Members are entitled to the same benefits upon the same conditions as are otherwise specified in the applicable Benefit Schedule. Therefore, the Group Medical and Hospital Service Agreement and the applicable Benefit Schedule or Schedules are amended as follows:

A. Group Medical and Hospital Service Agreement

1. Section 1-Q, Pre-Existing Condition, is deleted.
2. Section 6-B, the limitation on Pre-Existing Conditions is deleted.

B. Applicable Benefit Schedule or Schedules

Section H. PRE-EXISTING CONDITIONS, is deleted.

V. DIGESTS OF GROUP INSURANCE PLANS FOR PUBLIC-SCHOOL PERSONNEL, 1964-65, MAXIMUM ALLOWANCES AND BENEFITS

Dollar amounts shown in () are charges to the individual for the specified benefit.
Dollar amounts shown in [ ] are deductibles which must be satisfied by the individual before coinsurance can be applied or benefits received.

School system and underwriter of health plan	Hospitalization: Daily room and board	Surgical		Medical		Major medical		Maternity provisions for normal delivery		Coverage after retirement	Financing	
		Allowances	Benefits	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits		Cost per month	Contributor
1	2	3	4	5	6	7	8	9	10	11	12	13
Stratum 1--enrollment 100,000 and over												
CALIFORNIA												
Los Angeles												
California physicians service	3 or more bed ward for 180 days per illness	$200.00 100.00	Appendectomy Tonsillectomy	$ 5.00 5.00 10.00	Per day for 180 days in hospital Office visit Home call, home and office visit for employee only; start 3rd day of illness; 100 visits/year	[$100.00] 80% $20,000.00	Deductible/yr. Coinsurance Per lifetime	$ 50.00	Hospital care	Excludes major medical	Individual $ 4.71 7.38 5.00 Family 21.33 5.00	 employee (M) employee (W) system employee system
Blue Cross with major medical a/	3 or more bed ward for 180 days per illness	300.00 150.00 50.00	Single operation Appendectomy Tonsillectomy	3.00 3.00 4.50 225.00	Hospital visit Office visit Home call Per year for all visits	[$100.00] 80% $20,000.00	Deductible/yr. Coinsurance Per lifetime	50.00	Hospital care	Reduced benefits	Individual 5.32 7.95 5.00 Family 21.41 5.00	 employee (M) employee (W) system employee system
Occidental Life	Major medical		Major medical		Major medical	[$200.00] 80% 100% $20,000.00	Deductible/yr. Coinsurance for hospital Of scheduled medical and surgical Per lifetime		Major medical	Same coverage	Individual 0.70 5.00 Family 10.89 5.00	 employee system employee system
Kaiser Foundation	Full coverage for 125 days per year, 1/2 rate for 240 days		Full coverage	Full coverage (5.00)	In hospital and office visits Home call, no limit		None	(100.00) (175.00)	Full coverage after 10 months' membership Before 10 months' membership	Same coverage	Individual 4.05 5.00 Family 20.45 5.00	 employee system employee system
Ross-Loos and Independent Life	$22.00/day, $500.00 maximum hospital care, thereafter 80% coinsurance to $10,000		Full coverage	Full coverage (2.00) (5.00)	Hospital visits Office visit Home call		None	125.00 (50.00)	Hospital care Normal delivery and physician visits	Same coverage	Individual 6.04 5.00 Family 20.97 5.00	 employee system employee system
San Diego												
Pacific Mutual Life Insurance Co.	Major medical		Major medical		Major medical	[$75.00] 80% 100% $20,000.00	Deductible/yr. Coinsurance for hospital Of scheduled medical and surgical Per lifetime		Major medical	Same coverage	Individual None 7.58 Family 18.17 7.58	 employee system employee system
DISTRICT OF COLUMBIA												
Washington												
Blue Cross-Blue Shield a/	Semi-private for 365 days per illness	120.00 55.00	Appendectomy Tonsillectomy	18.00 12.00 6.00	1st day in hospital 2nd day Thereafter to 365 days	[$100.00] 80% $30,000.00	Deductible/illness Coinsurance Per lifetime	Basic coverage 85.00 Basic coverage	Hospital care Normal delivery Physicians visits	Same coverage	Individual 6.32 2.82 Family 17.07 6.76	 employee system employee system

1	2	3	4	5	6	7	8	9	10	11	12	13
Group Health Association[a]	Full coverage		Full coverage	Full coverage $ (5.00)	Hospital and office visits First home call in each illness			$(50.00) Full coverage	Hospital care Normal delivery and physicians visits	Same coverage	Individual $11.18 2.82 Family 28.75 6.76	 employee system employee system
Aetna Life Insurance Co.[a]	Major medical		Major medical		Major medical	[$50.00] 100% 80% $40,000.00	Deductible/yr. First $1,000 for hospital care Coinsurance Per lifetime		Major medical	Same coverage	Individual 6.15 2.82 Family 16.75 6.76	 employee system employee system
FLORIDA												
Dade Co. (Miami)												
Blue Cross-Blue Shield	$15.00/day for 120 days per illness	$333.00 117.00 50.00	Single operation Appendectomy Tonsillectomy	12.00 5.00	1st day in hospital Thereafter to 120 days	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	100.00 83.00	Hospital care Normal delivery	Excludes major medical	Individual 8.10 1.67 Family 21.85 1.67	 employee system employee system
Duval Co. (Jacksonville)												
Protective Life Insurance Co.	$11.00/day for 70 days per year extended coverage $7.00/day for 70 additional days	200.00 100.00 30.00	Single operation Appendectomy Tonsillectomy		None		None	100.00	Normal delivery	N.I.	Individual[b] 4.95 None Family[b] 10.95 None	 employee system employee system
GEORGIA												
Atlanta												
Blue Cross-Blue Shield	$15.00 for private, semi-private full coverage for 30 days per illness	250.00 125.00 42.50	Single operation Appendectomy Tonsillectomy		Major medical	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	10 days 75.00	Hospital care Normal delivery	N.I.	Individual 12.24 to 4.70 emp. None to 1.00 sys. Family 33.10 to 13.72 emp. None to 1.00 sys.	
LOUISIANA												
Orleans Parish (P.O. New Orleans)												
Blue Cross and Standard Life	$14.00/day for 125 days after [$25.00 [illegible] ductib[illegible] tende[illegible] age $1[illegible],000	200.00 100.00 35.00	Single operation Appendectomy Tonsillectomy	3.00	Per day for 50 days in hospital	$5,000.00	Over 3 years for specified diseases	10 days 50.00	Hospital care Normal delivery	Same coverage	Individual 6.47 None Family 17.60 None	 employee system employee system
MARYLAND												
Baltimore												
Educators Mutual Insurance Co.	$12.00/day for 70 days per illness	300.00	Single operation	75.00	All physician's visits			100.00	lump sum	N.I.	Individual[b] 7.63 None Family[b] 17.89 None	 employee system employee system
Montgomery Co.												
Blue Cross-Blue Shield	Full coverage for 31 days per illness; thereafter $10.00/day to 180 additional days	300.00 120.00 60.00	Single operation Appendectomy Tonsillectomy	15.00 10.00 5.00	1st visit in hospital 2nd and 3rd Thereafter to 177 visits	[$150.00] 80% $10,000.00	Deductible/90 days Coinsurance Per illness	150.00 105.00	Hospital care Normal delivery .	Same coverage	Individual 3.07% 3.07 Family 8.70 8.70	 employee system employee system

DIGESTS OF GROUP HEALTH INSURANCE PLANS FOR PUBLIC-SCHOOL PERSONNEL, 1964-65, MAXIMUM ALLOWANCES AND BENEFITS (Continued)
Dollar amounts shown in () are charges to the individual for the specified benefit.
Dollar amounts shown in [ ] are deductibles which must be satisfied by
the individual before coinsurance can be applied or benefits received.

School system and underwriter of health plan	Hospitalization:	Surgical		Medical		Major medical		Maternity provisions for normal delivery		Coverage after retirement	Financing	
	Daily room and board	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits		Cost per month	Contributor
1	2	3	4	5	6	7	8	9	10	11	12	13
Stratum 1--enrollment 100,000 and over (Cont.)												
MARYLAND (Cont.)												
Prince Georges Co. (Upper Marlboro)												
Blue Cross-Blue Shield	Semi-private for 180 days per illness	$300.00 120.00 55.00	Single operation Appendectomy Tonsillectomy	$ 15.00 10.00 5.00	1st day, start 3rd day in hospital 2nd day Thereafter to 177 days		None	$ 100.00 85.00	Hospital care Normal delivery	N.I.	Individual All None Family All None	 employee system employee system
MICHIGAN												
Detroit												
Provident Life and Accident Ins. Co.[a]	$22.00/day for 365 per illness		Scheduled fees	15.00 6.00 4.80	1st day in hospital 2nd - 19th Thereafter to 365 days	[$50.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	Basic coverage	Hospital, normal delivery and physicians visits	N.I.	Individual $ 1.23 9.21 Family 11.46 16.48	 employee[c] system employee system[c]
MISSOURI												
St. Louis												
Blue Cross-Blue Shield[a]	$12.00 for private, semi-private, full coverage for 70 days per illness; extended coverage at $6.00 for 180 days	300.00 150.00 50.00	Single operation Appendectomy Tonsillectomy	5.00 3.00 1.00	2nd - 8th day in hospital Thereafter to 70 days Additional for 2nd visit	[$100.00] 75% $5,000.00	Deductible/3 months Coinsurance Per illness	Basic coverage 90.00	Hospital care Normal delivery	N.I.	Individual 7.35 None Family 20.00 None	 employee system employee system
Continental Casualty[a]	$20.00/day for 120 days per illness	300.00 200.00 50.00	Single operation Appendectomy Tonsillectomy	5.00	Per day for 120 days in hospital	[$500.00] [$750.00] 80% $10,000.00	Deductible/illness Deductible age 50 and over Coinsurance Per two years	10 days 100.00	Hospital care Normal delivery	Same coverage	Individual[c] 5.04 None Family[c] 14.16 None	 employee system employee system
NEW YORK												
New York City												
Health Insurance Plan[a]	Semi-private for 21 days per illness, extended coverage for 180 days @ 50% discount		Full coverage		Full coverage $750.00 maximum outside medical group care		None	80.00 Full coverage	Hospital care Normal delivery and physicians visits	Same coverage	Individual 4.70 4.67 Family 12.45 12.41	 employee system employee system
OHIO												
Cleveland												
Blue Cross-Blue Shield	2 or 3 bed ward for 730 days per illness	50.00 165.00 75.00	Single operation Appendectomy Tonsillectomy	15.00 5.00 4.00 4.00 5.00 7.50	1st day in hospital Next 29 days Next 90 days Per visit next 610 days after [$50.00] deductible for post-hospital care Office visit Home call		None	Basic coverage 60.00	Hospital care Normal delivery	N.I.	Individual 11.75 None Family 23.50 None	 employee system employee system

1	2	3	4	5	6	7	8	9	10	11	12	13
Columbus												
Blue Shield	Semi-private for 120 days per illness	$ 300.00 125.00 60.00	Single operation Appendectomy Tonsillectomy	$ 10.00 5.00 4.00	1st day in hosp. Next 3 days Thereafter to 120 days		None	$ 80.00 50.00	Hospital care Normal delivery	N.I.	Individual $ 4.77 None Family 13.40 None	 employee system employee system
PENNSYLVANIA												
Philadelphia												
Blue Cross-major medical	Semi-private for 120 days per illness	300.00	Single operation	15.00 10.00 4.00 3.00 4.00 5.00	1st day in hospital 2nd Next 8 days Thereafter to 70 days Office visit Home call, office and home visits for employee only, start 4th day to 21 days per year	[$100.00] 80% $25,000.00	Deductible/yr. Coinsurance Per lifetime	6 days	Hospital care	Reduced benefits	Individual 4.09 part Family 15.06 part	 employee system employee system
TENNESSEE												
Memphis												
Metropolitan Life Insurance Co.	Major medical		Major medical		Major medical	[$50.00] 100% 80% $10,000.00	Deductible/yr. Next $300.00 hospital care Coinsurance Per lifetime	150.00	Normal delivery	Reduced benefits	Individual 2.25 part Family 10.28 part	 employee system employee system
TEXAS												
Dallas												
Blue Cross-Blue Shield, major medical	$12.00/day for 70 days per illness	300.00 150.00 40.00	Single operation Appendectomy Tonsillectomy	5.00	Per day for 30 days in hospital	[$100.00] 80% $5,000.00 $10,000.00	Deductible/yr. Coinsurance Per year Per lifetime	10 days 75.00	After [$25.00] deductible hospital care Normal delivery	Same coverage	Individual 2.65 4.17 Family 11.00 4.17	 employee[b/] system employee[b/] system
Houston												
Blue Cross-Blue Shield	$12.00/day for 120 days per illness after [$25.00] deductible	300.00 150.00	Single operation Appendectomy	4-6.00 300.00	Per day in hospital Maximum	[$100.00] 80% $10,000.00	Deductible/90 days Coinsurance Per year	Basic coverage 75.00 6.00 5.00	Hospital care Normal delivery 1st 5 physician's visits Next 5 visits	Same coverage	Individual 3.63 4.17 Family 13.95 4.17	 employee[b/] system employee[b/] system
WISCONSIN												
Milwaukee												
Blue Cross-Blue Shield, major medical	Semi-private for 70 days per illness	1,000.00 150.00 75.00	single operation Appendectomy Tonsillectomy	4.00	Per day for 70 days in hospital	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	Basic coverage 85.00	Hospital care Normal delivery	N.I.	Individual None 9.94 Family 16.61 9.94	 employee system employee system
Stratum 2--enrollment 50,000-99,999												
ALABAMA												
Jefferson Co. (excl. Birmingham)												
Blue Cross-Blue Shield	Semi-private for 70 days per illness after [$25.00] deductible	200.00 100.00 25.00	Single operation Appendectomy Tonsillectomy	3.00	Per day for 70 days in hospital		None	10 days 50.00	Hospital care Normal delivery	Same coverage	Individual 3.91 5.01 None Family 11.61 None	 employee (M) employee (W) system employee system

DIGESTS OF GROUP HEALTH INSURANCE PLANS FOR PUBLIC-SCHOOL PERSONNEL, 1964-65, MAXIMUM ALLOWANCES AND BENEFITS (Continued)
Dollar amounts shown in () are charges to the individual for the specified benefit.
Dollar amounts shown in [ ] are deductibles which must be satisfied by the individual before coinsurance can be applied or benefits received.

School system and underwriter of health plan	Hospitalization:	Surgical		Medical		Major medical		Maternity provisions for normal delivery		Coverage after retirement	Financing	
	Daily room and board	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits		Cost per month	Contributor
1	2	3	4	5	6	7	8	9	10	11	12	13
Stratum 2--enrollment 50,000-99,999 (Cont.)												
ALABAMA												
Mobile County												
Protective Life Insurance Co.	$12.00/day for 70 days per illness after [$25.00] deductible	$ 225.00 100.00 25.00	Single operation Appendectomy Tonsillectomy	$ 4.00	Per day for 70 days in hospital	[$1,000.00] 80% $5,000.00	Deductible of covered expense per year Coinsurance Per lifetime	$ 100.00	Hospital care and normal delivery	Same coverage	Individualb/ $ 9.10 None Familyb/ 16.32 None	 employee system employee system
CALIFORNIA												
Fresno												
Blue Shield	3 or more bed ward for 180 days per illness	1,500.00 275.00 130.00	Single operation Appendectomy Tonsillectomy	5.00 Varies	Per day for 180 days in hospital Office and home visits based on fee schedule for employee only, starts 3rd day of illness, 50 visits per year	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	50.00 50.00	Hospital care Normal delivery	Same coverage	Individual 2.84 6.00 Family 12.97 6.00	 employee system employee system
Long Beach												
Family Health Program	Ward for 125 days per illness		Full coverage	Full coverage (1.00) (5.00)	In hospital Office visits Home calls no limit		None	Full coverage	For hospital, delivery, and physicians visits	Same coverage	Individual 1.00 6.18 Family 15.67 6.18	 employee system employee system
Prudential Insurance	Major medical		Major medical		Major medical	[$50.00] 100% 80% $10,000.00	Deductible/yr. Scheduled fees for surgical and medical Hospital care Per lifetime	75.00	Lump sum	Same coverage	Individual None 6.18 Family 16.80 6.18	 employee system employee system
Kaiser Foundation	Full coverage for 125 days per year, 1/2 rate for 240 days		Full coverage	Full coverage (5.00)	Hospital and office visits Home call		None	(100.00) (175.00)	Full coverage after 10 mos. membership Before 10 mos. membership	Same coverage	Individual 2.12 6.18 Family 19.54 6.18	 employee system employee system
Oakland												
Kaiser Foundation	Full coverage for 111 days for illness in one year		Full coverage	Full coverage (1.00) (3.50)	Hospital visits Office visit 1st 2 routine home calls, no charge thereafter		None	(60.00) (140.00)	Full coverage after 10 mos. membership Before 10 mos. membership	Same coverage	Individual 0.20 8.00 Family 14.95 8.00	 employee system employee system
Blue Cross and major medical	3 bed ward for 180 days per illness	600.00	Single operation	4.00 4.00 6.00 300.00	Per day for 180 days in hospital Office visit Home call Maximum for office and home visits	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	50.00	Hospital care	Same coverage	Individual 2.03 8.00 Family 19.11 8.00	 employee system employee system
San Francisco												
Bay Medical Group	Full coverage		Full coverage	Full coverage (1.00) (5.00)	Hospital days Office visit Home call		None	Full coverage or 100.00	Within service area Lump sum upon election of member	N.I.	Individual 4.70 33% Family 17.76 Part	 employee system employee system

1	2	3	4	5	6	7	8	9	10	11	12	13
Basic and major medical	Fee schedule		Fee schedule	Fee schedule	5 visits/month for office or home visits	[$200.00] 75% $12,500.00 $20,000.00	Deductible/yr. Coinsurance Per year Per lifetime	$ 120.00	Lump sum	Same coverage	Individual 67% 33% Family N.I.	 employee system
Kaiser Foundation	Full coverage for 111 days per illness per year		Full coverage	Full coverage $ (1.00) (3.50)	In hospital and office Office visit for dependents 1st 2 routine home calls, no charge thereafter		None	Full coverage (60.00)	Subscriber Dependent	Same coverage	Individual $ 5.02 33% Family 19.02 Part	 employee system employee system
FLORIDA												
Broward Co. (Ft. Lauderdale)												
Blue Cross-Blue Shield, major medical	$14.00/day for 70 days per illness	$333.00	Single operation	12.00 5.00	1st day in hospital Thereafter to 31 days per year	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	80.00 83.00	Hospital care Normal delivery and physicians visits	N.I.	Individual 6.05 None Family 16.89 None	 employee system employee system
Orlando Co. (Orlando)												
Blue Cross-Blue Shield	Semi-private for 120 days per illness	333.00 117.00 50.00	Single operation Appendectomy Tonsillectomy	12.00 5.00	1st day in hospital Thereafter to 120 days		None	$ 100.00 83.00	Hospital care Normal delivery	Same coverage	Individual All None Family All None	 employee system employee system
Protective Life	$12.00/day for 120 days per illness	250.00	Single operation		None		None	100.00	Normal delivery	Same coverage	Individual 4.95 None Family 10.95 None	 employee[b/] system employee[b/] system
Palm Beach Co. (West Palm Beach)												
Blue Cross-Blue Shield, major medical	$18.00/day for 31 days per illness	333.00 117.00 50.00	Single operation Appendectomy Tonsillectomy	12.00 5.00	1st day in hospital Thereafter for 31 days	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	80.00 83.00	Hospital care Normal delivery	Major medical reduced benefits	Individual 4.29 None Family 14.53 None	 employee system employee system
Pinellas Co. (Clearwater)												
Blue Cross-Blue Shield, major medical	$12.00/day for 70 days per illness	333.00 117.00 50.00	Single operation Appendectomy Tonsillectomy	12.00 5.00 375.00	1st day in hospital Thereafter to 70 days Maximum	[$100.00] 80% $5,000.00 $10,000.00	Deductible/yr. Coinsurance Per year Per lifetime	80.00 83.00	Hospital care Normal delivery	N.I.	Individual 5.84 None Family 15.64 None	 employee system employee system
GEORGIA												
Dekalb Co. (Decatur)												
Provident Life and Accident Insurance Co.	$15.00/day for 31 days per illness	300.00 150.00 45.00	Single operation Appendectomy Tonsillectomy		Major medical	[$50.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	150.00	Lump sum	Excludes major medical	Individual 1.45 Basic cov. Family 8.41 Emp. basic cov. system	 employee system employee

DIGESTS OF GROUP HEALTH INSURANCE PLANS FOR PUBLIC-SCHOOL PERSONNEL, 1964-65, MAXIMUM ALLOWANCES AND BENEFITS (Continued)
Dollar amounts shown in () are charges to the individual for the specified benefit.
Dollar amounts shown in [ ] are deductibles which must be satisfied by the individual before coinsurance can be applied or benefits received.

School system and underwriter of health plan	Hospitalization:	Surgical		Medical		Major medical		Maternity provisions for normal delivery		Coverage after retirement	Financing	
	Daily room and board	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits		Cost per month	Contributor
1	2	3	4	5	6	7	8	9	10	11	12	13
Stratum 2--enrollment 50,000-99,999 (Cont.)												
KENTUCKY												
Jefferson Co. (excl. Louisville)												
Blue Cross-Blue Shield	$15.00/day for 70 days per illness	$225.00 100.00 30.00	Single operation Appendectomy Tonsillectomy	$ 5.00	Per day, starts 4th day in hospital to 27 days per year		None	10 days $ 50.00	Hospital care Normal delivery	Same coverage	Individual $ 4.65 None Family 11.45 None	 employee system employee system
Louisville												
Blue Cross-Blue Shield preferred[a]	$15.00/day for 70 days per illness	300.00 150.00 40.00	Single operation Appendectomy Tonsillectomy	5.00	Per day for 30 days in hospital		None	10 days 90.00	Hospital care Normal delivery	Same coverage	Individual All None Family All None	 employee system employee system
LOUISIANA												
Caddo Parish (Shreveport)												
Washington National Insurance Co.[a]	$14.00/day for 120 days per illness	300.00	Single operation	4.00 480.00	Per day for 120 days in hospital Maximum	$10,000.00	Over 3 years for specified diseases	14.00 75.00	Hospital care Normal delivery	Same coverage	Individual[b] 4.70 5.24 Family[b] 18.53 5.24	 employee system employee system
East Baton Rouge Parish (Baton Rouge)												
Pan American Life[a]	$16.00/day for 31 days per illness	300.00 150.00 45.00	Single operation Appendectomy Tonsillectomy	5.00 155.00	Per day for 31 days in hospital Maximum	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per illness	160.00 75.00	Hospital care Normal delivery	Same coverage	Individual 3.05 3.06 Family 18.74 16.50 3.06	 employee system employee (M) employee (W) system
MASSACHUSETTS												
Boston												
Blue Cross and Blue Shield	Semi-private for 120 days per illness after [$25.00] deductible	125.00 35.00	Appendectomy Tonsillectomy	10.00 5.00	First day in hospital Thereafter to 120 days	$5,000.00	For specified diseases	Basic coverage 75.00	Hospital care Physician's visits	Same coverage	Individual[b] 3.61 3.60 Family[b] 10.34 10.47	 employee system employee system
MINNESOTA												
Minneapolis												
Northwestern National Life Insurance Co.	$26.00/day for 120 days per illness	300.00 150.00 45.00	Single operation Appendectomy Tonsillectomy	4.00 480.00	Per day for 120 days in hospital Maximum	[$100.00] 80% $15,000.00	Deductible/yr. Coinsurance Per lifetime	225.00 75.00	Hospital care Normal delivery	None	Individual 2.18 6.91 Family 10.70 13.63	 employee system[b] employee system[b]

1	2	3	4	5	6	7	8	9	10	11	12	13
MISSOURI												
Kansas City												
Continental Casualty Co.[a]	$20.00/day for 120 days per illness	$300.00 200.00 50.00	Single operation Appendectomy Tonsillectomy	$ 5.00 600.00	Per day for 120 days in hospital Maximum	[$500.00] [$750.00] 80% $10,000.00	Deductible/2 yrs. (50 and under) Deductible/2 yrs. (over 50) Coinsurance Per 2 yrs.	Basic coverage Fee schedule	Hospital care Normal delivery	N.I.	Individual $ 9.26 None Family 14.77 None	 employee system employee system
NEBRASKA												
Omaha												
Blue Cross-Blue Shield, major medical[a]	Semi-private for 150 days per illness	480.00 180.00 60.00	Single operation Appendectomy Tonsillectomy	12.00 6.00	1st day in hospital Thereafter to 150 days	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	Basic coverage $ 100.00	Hospital care Normal delivery	None	Individual 9.20 None Family 20.95 None	 employee system employee system
NEVADA												
Clark Co. (Las Vegas)												
United Benefit Life Ins. Co.	$15.00/day for 31 days per illness	300.00 150.00 45.00	Single operation Appendectomy Tonsillectomy	5.00 55.00	Per day in hospital Maximum	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	100.00	Lump sum	Same coverage	Individual[b] 4.18 4.18 Family 20.77 4.18	 employee system employee system
NEW MEXICO												
Albuquerque												
Equitable Life Assurance Society	Major medical		Major medical		Major medical	[$50.00] [$75.00] [$100.00] 80% $15,000.00	Deductible/yr. less than $5,000 earning $5,000 less than $10,000 $10,000 or more earning Coinsurance Per lifetime	150.00	Normal delivery	Same coverage	Individual 6.57 20% Family 16.87 Part	 employee system employee system
NEW YORK												
Buffalo												
Blue Cross-Blue Shield extended benefits	Semi-private for 120 days per illness	500.00 150.00 100.00	Single operation Appendectomy Tonsillectomy	15.00 10.00 5.00 3.00 455.00	1st day in hospital 2nd day 3rd thru 40th day Thereafter to 120 days Maximum	0 80% $15,000.00	No deductible Coinsurance Per 3-year period	80.00	Normal delivery	Excludes major medical	Individual 8.85 None Family 20.97 None	 employee system employee system
OHIO												
Akron												
Blue Cross-Blue Shield, Pouleen Insurance	2 or more bed wards for 120 days per illness.	200.00 100.00 35.00	Single operation Appendectomy Tonsillectomy	5.00 3.00	1st and 2nd day in hospital Therafter to 70 days	[$75.00] 75% $5,000.00	Deductible/yr. Coinsurance Per lifetime	Basic coverage 50.00	Hospital care Normal delivery	Excludes major medical	Individual 11.02 None Family 22.72 None	 employee system employee system
Cincinnati												
Blue Cross-Blue Shield	2 or more bed wards for 365 days per illness	300.00 125.00 60.00	Single operation Appendectomy Tonsillectomy	10.00 5.00 4.00	1st day in hospital 2nd thru 4th Thereafter to 120 days		None	Basic coverage 50.00	Hospital care Normal delivery	Same coverage	Individual 7.35 None Family 18.00 None	 employee system employee system

DIGESTS OF GROUP HEALTH INSURANCE PLANS FOR PUBLIC-SCHOOL PERSONNEL, 1964-65, MAXIMUM ALLOWANCES AND BENEFITS (Continued)

Dollar amounts shown in () are charges to the individual for the specified benefit.
Dollar amounts shown in [ ] are deductibles which must be satisfied by the individual before coinsurance can be applied or benefits received.

School system and underwriter of health plan	Hospitalization: Daily room and board	Surgical		Medical		Major medical		Maternity provisions for normal delivery		Coverage after retirement	Financing	
		Allowances	Benefits	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits		Cost per month	Contributor
1	2	3	4	5	6	7	8	9	10	11	12	13
Stratum 2--enrollment 50,000-99,999 (Cont.)												
OHIO (Cont.)												
Dayton												
Blue Cross-Blue Shield	2 or more bed wards for 120 days per illness	$200.00 100.00 35.00	Single operation Appendectomy Tonsillectomy	$ 5.00 3.00	1st and 2nd day in hospital Thereafter to 70 days		None	Basic coverage $ 50.00	Hospital care Normal delivery	N.I.	Individual $ 6.72 None Family 16.62 None	 employee system employee system
Toledo												
Blue Cross-Blue Shield, Phoenix Mutual Life Insurance Co.	Semi-private for 70 days per illness	200.00	Single operation	5.00 3.00	1st and 2nd days in hospital Thereafter to 70 days	[$100.00] 80% $10,000.00	Deductible/yr. with basic coverage Coinsurance Per lifetime	Basic coverage Fee schedule	Hospital care Normal delivery	Major medical reduced benefits	Individual All None Family All None	 employees system employees system
OKLAHOMA												
Tulsa												
Blue Cross-Blue Shield	Semi-private for 90 days per illness after [$25.00] deductible	300.00 100.00 40.00	Single operation Appendectomy Tonsillectomy	5.00 4.00	1st thru 15th day in hospital Thereafter to 90 days	$7,000.00	Over 2 years for specified diseases	10 days 60.00	Hospital care Normal delivery	N.I.	Individual 50% 50% Family Part Part	 employee system employee system
OREGON												
Portland												
Blue Cross	4 bed ward or $22.00/day for 100 days per illness	350.00 150.00 50.00	Single operation Appendectomy Tonsillectomy	4.00 3.00 4.50	Per day for 100 days in hospital Office visit Home call, home and office visits for employee only, starts 2nd day of illness, $225.00 maximum		None	100.00 50.00	Hospital care Normal delivery	N.I.	Individual 5.75 7.60 None Family 15.70 16.25 None	 employee(M) employee(W) system employee(M) employee(W) system
O.P.S. Blue Shield	$13.00/day for 70 days per year, after [$15.00] deductible		Full coverage	Full coverage	For 70 days in hospital		None	60.00 50.00	Hospital care Normal delivery	N.I.	Individual 6.37 6.94 None Family 16.53 None	 employee(M) employee(W) system employee system
Kaiser Foundation	Full coverage for 111 days per illness, 70 days for dependents		Full coverage	Full coverage (1.00) (2.00)	In hospital Office visit Home call, no limit		None	Full coverage (120.00)	After 10 months' membership Before 10 months' membership	N.I.	Individual 7.75 None Family 19.95 None	 employee system employee system

1	2	3	4	5	6	7	8	9	10	11	12	13
PENNSYLVANIA												
Pittsburgh												
Blue Cross-Blue Shield[a]	Semi-private or 85% of private room for 70 days per illness	$300.00 150.00 50.00	Single operation Appendectomy Tonsillectomy	$ 15.00 10.00 4.00 3.00 5.00 7.00	1st day in hospital 2nd day 3rd thru 10th day Thereafter to 70 hospital days Office visit Home call, office or home calls, for employee only, starts 4th visit to 21 visits/yr.	[$100.00] 80% $10,000.00	Deductible/3 months Coinsurance Per illness	10 days $ 90.00	Hospital care Normal delivery	Major medical reduced benefits	Individual $ 3.08 8.94 Family 26.02 8.94	 employee system employee system
SOUTH CAROLINA												
Greenville Co.												
Blue Cross-Blue Shield	Semi-private for 70 days per illness after [$20.00] deductible	250.00 90.00 35.00	Single operation Appendectomy Tonsillectomy	4.00	Per day, start 3rd day to 70 days in hospital	$10,000.00	For specified illnesses or diseases	10 days 55.00	Hospital care Normal delivery	N.I.	Individual 4.85 None Family 11.70 None	 employee system employee system
TENNESSEE												
Nashville-Davidson Co.												
Provident Life and Accident Insurance Co.	$8.00/day for 31 days per illness	300.00 115.00 50.00	Single operation Appendectomy Tonsillectomy		Major medical	[$500.00] 75% $10,000.00	Deductible/yr. Coinsurance Per lifetime	80.00 60.00	Hospital care Normal delivery	N.I.	Individual 4.95 None Family 15.21 None	 employee system employee system
TEXAS												
El Paso												
Blue Cross-Blue Shield, major medical	$12.00/day for 70 days per illness	300.00 150.00	Single operation Appendectomy	5.00	Per day, starts 4th day to 30 days in hospital	[$100.00] 80% $5,000.00 $10,000.00	Deductible/yr. Coinsurance Per year Per lifetime	Basic coverage 75.00	Hospital care Normal delivery	N.I.	Individual All None Family N.I.	 employee system
Fort Worth												
Blue Cross-Blue Shield, major medical	$12.00/day for 70 days per illness	300.00 150.00 40.00	Single operation Appendectomy Tonsillectomy	5.00 150.00	Per day, starts 4th day to 30 days in hospital Maximum	[$100.00] 80% $5,000.00 $10,000.00	Deductible/yr. Coinsurance Per year Per lifetime	10 days 75.00	Hospital care Normal delivery	Same coverage	Individual 5.16 None Family 13.57 None	 employee system employee system
San Antonio												
Blue Cross-Blue Shield, major medical	$12.00/day for 70 days per illness	300.00	Single operation	5.00 150.00	Per day, starts 4th day to 30 days in hospital Maximum	[$100.00] 80% $5,000.00 $10,000.00	Deductible/yr. Coinsurance Per year Per lifetime	10 days 75.00	Hospital care Normal delivery	Same coverage	Individual All None Family N.I.	 employee system
UTAH												
Granite School Dist. (P.O. Salt Lake City)												
Utah Teachers Welfare Association	3 bed ward for 70 days per illness, thereafter 80% of charges	85%	Of fee schedule by Utah State Medical Association	[25.00] 100% 80%	Deductible/illness Next $75.00 Thereafter	$5,000.00	Per three yrs. for hospital, surgical and medical	10 days 100.00	Hospital care Normal delivery	Same coverage	Individual None All Family N.I.	 employee system

DIGESTS OF GROUP HEALTH INSURANCE PLANS FOR PUBLIC-SCHOOL PERSONNEL, 1964-65, MAXIMUM ALLOWANCES AND BENEFITS (Continued)
Dollar amounts shown in () are charges to the individual for the specified benefit.
Dollar amounts shown in [ ] are deductibles which must be satisfied by the individual before coinsurance can be applied or benefits received.

School system and underwriter of health plan	Hospitalization: Daily room and board	Surgical		Medical		Major medical		Maternity provisions for normal delivery		Coverage after retirement	Financing	
		Allowances	Benefits	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits		Cost per month	Contributor
1	2	3	4	5	6	7	8	9	10	11	12	13
Stratum 2--enrollment 50,000-99,999 (Cont.)												
VIRGINIA												
Fairfax Co.												
Blue Cross-Blue Shield	Semi-private for 180 days per illness	$300.00	Single operation	$ 5.00 885.00	Per day, starts 4th day to 177 days in hospital Maximum	[$50.00] 80% $10,000.00	Deductible/90 days Coinsurance Per illness	$ 100.00 85.00	Hospital care Normal delivery	Same coverage	Individual $ 3.44 3.44 Family 13.93 3.44	 employee system employee system
Stratum 3--enrollment 25,000-49,999												
ALABAMA												
Montgomery Co.												
Blue Cross-Blue Shield	Semi-private for 70 days per illness		Major medical		Major medical	[$100.00] 80% $5,000.00 $10,000.00	Deductible/yr. Coinsurance Per year Per lifetime	10 days Major medical	Hospital care Normal delivery and physician's visits	N.I.	Individual All None Family N.I.	 employee system
ARIZONA												
Tucson												
Blue Cross-Blue Shield[a]/	Semi-private for 120 days per illness	350.00 124.00 53.00	Single operation Appendectomy Tonsillectomy	7.00 4.00	Per day, starts 3rd day to 7th day in hospital Thereafter to 120 days		None	80.00 100.00	Hospital care Normal delivery	Same coverage	Individual 8.30 None Family 18.32 None	 employee system employee system
CALIFORNIA												
Anaheim Union High School Dist.												
Aetna Life	Major medical		Major medical		Major medical	[$50.00] 100% 80% $10,000.00	Deductible/yr. Of next $500.00 for hospital expense Coinsurance Per lifetime	100.00	Lump sum, no deductibles	None	Individual 3.80 3.80 Family 20.37 3.80	 employee system employee system
Fremont												
California Physicians' Service and Guardian Life Insurance Co.	3 or more bed ward for 31 days per illness	160.00 80.00	Appendectomy Tonsillectomy	4.00 4.00 8.00	Per day for 31 days in hospital Office visit Home call--routine, office or home visits, start 3rd day for illness to 100 visits per year	[$500.00] 100% $10,000.00	Deductible/90 days (basic coverage applies Coverage Per illness	50.00 50.00	Hospital care Normal delivery	Reduced benefits	Individual 1.56 8.16 Family 10.39 16.32	 employee system employee system
Kaiser Foundation	Full coverage for 111 days per illness		Full coverage	Full coverage (1.00) (3.50)	In hospital Office visit Home call--routine, no charge after first two visits		None	(60.00)	Full coverage	N.I.	Individual 0.19 8.16 Family 5.73 16.32	 employee system employee system

1	2	3	4	5	6	7	8	9	10	11	12	13
Hayward												
Kaiser Foundation	Full coverage for 111 days per illness		Full coverage	Full coverage $ (1.00) (3.50)	In hospital Office visit Home call--routine, no charge after first two visits		None	$ (60.00) (140.00)	Full coverage after 10 months membership After 10 months membership	N.I.	Individual $ 7.95 None Family 22.70 None	 employee system employee system
Blue Cross	3 or more bed ward for 180 days per illness	$300.00 150.00 50.00	Single operation Appendectomy Tonsillectomy	3.00 3.00 4.50	Per day for 180 days in hospital Office visit Home call, office or home visits for employee only, start 3rd visit for illness, $225.00 per year	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	50.00	Hospital care	N.I.	Individual 8.64 10.88 None Family 21.63 None	 employee(M) employee(W) system employee system
Mt. Diablo School Dist., (Concord)												
Blue Cross	3 or more bed ward for 180 days per illness	300.00 150.00 50.00	Single operation Appendectomy Tonsillectomy	3.00 3.00 4.50	Per day for 180 days in hospital Office visit Home call, office or home visits for employee only, starts 3rd day of illness $225.00 per year	[$[illegible].00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	50.00	Hospital care	Major medical reduced benefits	Individual 3.70 6.01 5.00 Family 16.92 5.00	 employee(M) employee(W) system employee system
Kaiser Foundation	Full coverage for 111 days per illness		Full coverage	Full coverage (1.00) (3.50)	In hospital Office visit Home call--routine, no charge after first two visits		None	(60.00) (140.00)	Full coverage after 10 months' membership Before 10 months' membership	Same coverage	Individual 3.20 5.00 Family 17.95 5.00	 employee system employee system
Pasadena												
Koss Loos and Independent Life	$20.00/day, $5,000.000 maximum for hospital care	(25.00)	Full coverage For dependents	Full coverage (1.25) (5.00)	In hospital Office visit Home call, no limits	[$100.00] 80% $5,000.00	Deductible/yr. Coinsurance Per lifetime	Basic coverage (50.00) Basic coverage	Hospital care Normal delivery Physicians visits	Reduced benefits	Individual 4.45 5.00 Family 16.78 5.00	 employee system employee system
Blue Cross	3 bed ward for 180 days per illness	300.00 150.00 50.00	Single operation Appendectomy Tonsillectomy	3.00 3.00 4.50	Per day for 180 days in hospital Office visit Home call, office or home visits for employee only, starts 3rd day of illness, $225.00 per year	[$100.00] 80% $20,000.00	Deductible/yr. Coinsurance Per lifetime	50.00	Hospital care	Reduced benefits	Individual 3.10 5.18 5.00 Family 15.77 5.00	 employee(M) employee(W) system employee system
Occidental Life	Major medical		Major medical		Major medical	[$200.00] 80% 100% $20,000.00	Deductible/yr. Coinsurance for hospital Of scheduled surgical and medical Per lifetime		None	Reduced benefits	Individual 1.37 5.00 Family 12.48 5.00	 employee system employee system
Richmond												
Kaiser Foundation	Full coverage for 111 days per illness		Full coverage	Full coverage Full coverage (3.50)	In hospital Office visits Home call--routine, no charge after first two visits		None	(60.00)	Full coverage	Same coverage	Individual All None Family N.I.	 employee system

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DIGESTS OF GROUP HEALTH INSURANCE PLANS FOR PUBLIC-SCHOOL PERSONNEL, 1964-65, MAXIMUM ALLOWANCES AND BENEFITS (Continued)
Dollar amounts shown in () are charges to the individual for the specified benefit.
Dollar amounts shown in [ ] are deductibles which must be satisfied by the individual before coinsurance can be applied or benefits received.

School system and underwriter of health plan 1	Hospitalization: Daily room and board 2	Surgical Allowances 3	 Benefits 4	Medical Allowances 5	 Benefits 6	Major medical Allowances 7	 Benefits 8	Maternity provisions for normal delivery Allowances 9	 Benefits 10	Coverage after retirement 11	Financing Cost per month 12	 Contributor 13
Stratum 3--enrollment 25,000-49,999 (Cont.)												
CALIFORNIA (Cont.)												
Richmond (Cont.)												
Blue Cross	3 or more bed ward for 180 days per illness	$ 300.00 150.00 50.00	Single operation Appendectomy Tonsillectomy	$ 3.00 3.00 4.50	Per day for 180 days in hospital Office visit Home call, office and home visits for employee only, starts 3rd day of illness, $225.00 per year	[$100.00] $80.00 $5,000.00 $10,000	Deductible/yr. Coinsurance Per illness Per lifetime	$ 50.00	Hospital care	N.I.	Individual None All Family N.I.	 employee system
Sacramento												
Equitable Life Assurance Society	$22.00/day for 31 days per illness	400.00 200.00 60.00	Single operation Appendectomy Tonsillectomy	5.00 155.00	A day for 31 days in hospital Maximum	5% of annual earnings 75% $10,000.00	Deductible/6 months (not less than $200.00 or more than $600.00) Coinsurance Per lifetime		None	None	Individual None 100% Family $12.45	 employee system b/ employee Emp. cov. system
San Bernardino												
Kaiser Foundation	Full coverage for 125 days per year, 240 days at 1/2 rate		Full coverage	Full coverage (5.00)	In hospital and office visits Home call, no limit		None	(100.00) (175.00)	Full coverage after 10 months' membership Before 10 months' membership	Same coverage	Individual 1.15 8.20 Family 19.25 8.20	 employee system employee system
California Physicians Service	3 bed ward for 120 days per illness	1,100.00	Single operation	660.00 330.00	120 days in hospital Maximum Maximum per year for office and home visits, starts 3rd day of illness	[$100.00] 80% $20,000.00	Deductible/yr. Coinsurance Per illness		None	Same coverage	Individual 1.31 8.20 Family 18.42 8.20	 employee system employee system
San Jose												
Occidental Life	$16.00/day, $496.00 maximum per illness, $14.00-$434.00 for dependents	300.00 150.00 52.50	Single operation Appendectomy Tosillectomy	4.50 139.50	Per day in hospital Maximum $4.00-$124.00 for dependents	$3,000.00	For specified diseases		None	N.I.	Individual 5.95 8.22 None Family 16.74 None	 employee(M) employee(W) system employee system
Kaiser Foundation	Full coverage for 111 days per illness, 60 days for dependents		Full coverage	Full coverage (1.00) (3.50)	In hospital Office visit Home call--routine, no charge after first two visits		None	(60.00) (95.00) (140.00)	Full coverage after 10 months' membership Dependents Before 10 months' membership	Same coverage	Individual 7.95 None Family 19.45 None	 employee system employee system

1	2	3	4	5	6	7	8	9	10	11	12	13
San Juan School Dist. (Carmichael)												
California Physicians Service	3 bed ward for 180 days per illness	$ 200.00 100.00	Appendectomy Tonsillectomy	$ 5.00 5.00 10.00	Per day, routine for 180 days in hospital Office visit--routine Home call--routine, office and home visit for employee only, starts 3rd day of illness, 100 visits per year	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	$ 100.00	Hospital care	Reduced benefits	Individual $ 3.16 7.75 Family 16.20 7.75	 employee system employee system
Stockton												
Continental Casualty Co.	$20.00/day for 120 days per illness	1,000.00 200.00 100.00	Single operation Appendectomy Tonsillectomy	5.00 7.50 350.00	Per visit for hospital and office Home call Maximum per year for all visits, home and office visits for employee only	[$100.00] 80% $5,000.00	Deductible/6 months Coinsurance Per illness	50.00 50.00	Hospital care Normal delivery	Same coverage	Individual ... 7.86 Family 13.86 7.86	 employee system employee system
Torrance												
Blue Cross	3 or more bed ward for 180 days per illness	300.00 150.00 50.00	Single operation Appendectomy Tonsillectomy	3.00	Per day for 180 days in hospital	[$100.00] 80% $5,000.00 $10,000.00	Deductible/yr. Coinsurance Per illness Per lifetime	50.00	Hospital care	Excludes major medical	Individual All None Family N.I.	 employee system
Kaiser Foundation	Full coverage for 125 days per year, 240 days at 1/2 rate		Full coverage	Full coverage (2.00) (5.00)	In hospital Office visit Home call, no limit		None	(100.00) (175.00)	Full coverage after 10 months membership Before 10 months membership		Individual All None Family N.I.	 employee system
COLORADO												
Colorado Springs												
Equitable Life Assurance Society	Major medical		Major medical		Major medical	[$50.00] 100% 80% $10,000.00	Deductible/yr. First $500.00 of hospital care Coinsurance or scheduled surgical fees whichever higher Per lifetime	200.00	Lump sum, no deductible	Same coverage, no reinstatement	Individual 4.68 6.64 Family 13.92 12.30	 employee system employee system
Jefferson Co., (P.O., Denver)												
Insurance Services Commission[a]/	$24.00/day for 365 days per illness	150.00 50.00	Appendectomy Tonsillectomy plus 80% of excess of scheduled fees	5.00 4.00	Per day for first 50 days in hospital Thereafter to 365			Basic coverage 100.00	Hospital care Normal delivery	Same coverage	Individual 11.60 None Family 28.90 None	 employee system employee system
Insurance Services Commission[a]/	Major medical		Major medical		Major medical	[$100.00] 80% $10,000.00 $20,000.00	Family deductible/yr. Coinsurance Per year Per lifetime		Major medical	Same coverage	Individual 10.00 None Family 24.00 None	 employee system employee system

DIGESTS OF GROUP HEALTH INSURANCE PLANS FOR PUBLIC-SCHOOL PERSONNEL, 1964-65, MAXIMUM ALLOWANCES AND BENEFITS (Continued)
Dollar amounts shown in () are charges to the individual for the specified benefit.
Dollar amounts shown in [ ] are deductibles which must be satisfied by the individual before coinsurance can be applied or benefits received.

School system and underwriter of health plan	Hospitalization: Daily room and board	Surgical		Medical		Major medical		Maternity provisions for normal delivery		Coverage after retirement	Financing	
		Allowances	Benefits	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits		Cost per month	Contributor
1	2	3	4	5	6	7	8	9	10	11	12	13
Stratum 3--enrollment 25,000-49,999 (Cont.)												
CONNECTICUT												
Hartford												
											Individual	
Blue Cross-Blue Shield	$15.00/day for 120 days per illness, extended coverage for 1 year or $7,500	$350.00	Single operation	$ 6.00	Per day for 4th-8th day in hospital	[$100.00]	Deductible/disability	$ 125.00	Hospital care	None	None	employee
				5.00	Next 10 days	80%	Coinsurance	75.00	Normal delivery		100%	system
				4.00	Thereafter to 120 days per year	$5,000.00	Per lifetime				Family	
											$15.35	employee
											Emp. cov.	system
FLORIDA												
Brevard Co. (Titusville)												
											Individual	
Fidelity and Guaranty Life Ins.	Semi-private for 120 days per illness	330.00	Single operation	12.00	1st day in hospital	[$100.00]	Deductible/yr.	80.00	Hospital care	Excluded major medical	6.20	employee
		165.00	Appendectomy	5.00	Thereafter to 120 days	80%	Coinsurance	75.00	Normal delivery		None	system
						$5,000.00	Per year				Family	
				600.00	Maximum	$10,000.00	Per lifetime				18.40	employee
											None	system
Polk Co. (Bartow)												
											Individual	
Aetna Life Insurance Co.	$15.00/day for 31 days per illness after [$25.00] deductible	300.00	Single operation	5.00	Per day for 31 days in hospital	[$100.00]	Deductible/yr.	150.00	Lump sum	Same coverage	1.70	employee
		110.00	Appendectomy			80%	Coinsurance				3.52	system
		40.00	Tonsillectomy	155.00	Maximum	$7,500.00	Per lifetime				Family	
											12.68	employee
											3.52	system
Volusia Co. (DeLand)												
											Individual	
Provident Life and Accident Insurance Co.	$14.00/day for 70 days per illness, $980.00 maximum	300.00	Single operation		Major medical	[$100.00]	Deductible/yr.	150.00	Lump sum	Reduced benefits	5.42	employee
		110.00	Appendectomy			80%	Coinsurance				None	system
		40.00	Tonsillectomy			$5,000.00	Per lifetime				Family	
											14.17	employee
											None	system
GEORGIA												
Cobb Co. (Marietta)												
											Individual[b]	
Protective Life Insurance Co.	Semi private for 21 days per illness, thereafter 80% of semi private to 120 days	350.00	Single operation	5.00	Per day for 70 days in hospital		None	200.00	Lump sum	N.I.	6.74	employee
		175.00	Appendectomy								1.00	system
		52.50	Tonsillectomy								Family	
											15.93	employee
											1.00	system
Fulton Co. (excl. Atlanta)												
											Individual	
Home Life Insurance Co.	Major medical		Major medical		Major medical	[$100.00]	Deductible/90 days		None	None	5.20	employee
						100%	First $300.00 for hospital care				1.67	system
											Family	
											8.75	employee(M)
						80%	Coinsurance				8.10	employee(W)
						$5,000.00	Per illness				6.18	system

1	2	3	4	5	6	7	8	9	10	11	12	13
Muscogee Co. (Columbus)												
Blue Cross-Blue Shield[a]	$20.00/day for 120 days per illness	$300.00 150.00 68.00	Single operation Appendectomy Tonsillectomy	Fee schedule	According to illness	0 100% 80% $10,000.00	No deductible Hospital and medical (non-surgical) care Nursing, physical therapy and drugs Per lifetime	7 days $ 90.00	Hospital care Normal delivery	N.I.	Individual $ 8.85 None Family 22.15 None	 employee system employee system
ILLINOIS												
Rockford												
Woodmen Accident and Life Co. (Custodial Personnel)	$20.00/day for 31 days per illness	300.00 150.00 40.00	Single operation Appendectomy Tonsillectomy	$ 5.00 350.00	Per day for 31 days in hospital Maximum	[$100.00] 80% $10 000.00	Deductible/yr. Coinsurance Per lifetime	100.00 100.00	Hospital care Normal delivery	Same coverage	Individual None 6.45 Family 10.26 6.45	 employee system[b] employee system
Blue Cross-Blue Shield	Semi-private for 120 days per illness ($1.50) per day members payment	300.00 150.00 40.00	Single operation Appendectomy Tonsillectomy	8.00 5.00 3.00	1st day in hospital 2nd-7th day Thereafter to 70 days		None	75.00 75.00	Hospital care Normal delivery	Same coverage	Individual 5.15 None Family 13.61 None	 employee system employee system
Illinois Hospital Service	Semi-private for 70 days per illness	200.00 100.00 27.00	Single operation Appendectomy Tonsillectomy	5.00 3.00 2.00	1st day in hospital 2nd-7th day Thereafter to 70 days		None	10 days 50.00	Hospital care Normal delivery	Same coverage	Individual 3.40 None Family 9.80 None	 employee system employee system
INDIANA												
Ft. Wayne												
Blue Cross-Blue Shield	2 or more bed ward for 365 days per illness	300.00 150.00 60.00	Single operation Appendectomy Tonsillectomy	15.00 10.00 4.00 3.00	1st day in hospital 2nd day Next 8 days Thereafter to 120 days		None	Basic coverage 100.00	Hospital care Normal delivery	None	Individual 2.27 4.17 Family 13.17 4.17	 employee system employee system
Gary												
Blue Cross-Blue Shield, major medical	Semi-private for 120 days per illness	500.00 150.00 60.00	Single operation Appendectomy Tonsillectomy	15.00 10.00 4.00 3.00 387.00	1st day in hospital 2nd day Next 8 days Thereafter to 120 days Maximum	[$100.00] 80% $10,000.00	Deductible/3 months Coinsurance Per illness	Basic coverage 100.00	Hospital care Normal delivery	N.I.	Individual 7.49 None Family 14.91 None	 employee system employee system
KANSAS												
Kansas City												
Continental Casualty Co.[a]	$20.00/day for 70 days per illness	300.00	Single operation	5.00	Per day for 70 days in hospital	[$500.00] 75% $10,000.00	Deductible/illness (basic plan applies) Coinsurance Per lifetime	10 days Fee schedule	Hospital care Normal delivery	Same coverage	Individual 13.98 None Family 28.21 None	 employee[b] system employee system

DIGESTS OF GROUP HEALTH INSURANCE PLANS FOR PUBLIC-SCHOOL PERSONNEL, 1964-65, MAXIMUM ALLOWANCES AND BENEFITS (Continued)
Dollar amounts shown in () are charges to the individual for the specified benefit.
Dollar amounts shown in [ ] are deductibles which must be satisfied by the individual before coinsurance can be applied or benefits received.

School system and underwriter of health plan	Hospitalization: Daily room and board	Surgical		Medical		Major medical		Maternity provisions for normal delivery		Coverage after retirement	Financing	
		Allowances	Benefits	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits		Cost per month	Contributor
1	2	3	4	5	6	7	8	9	10	11	12	13
Stratum 3--enrollment 25,000-49,999 (Cont.)												
LOUISIANA												
Calcasieu Parish (Lake Charles)												
John Hancock Mutual Life Insurance Co.	$14.00/day for 120 days per illness	$200.00 100.00 30.00	Single operation Appendectomy Tonsillectomy	$ 5.00 350.00	Per day for 70 days in hospital Maximum	[$100.00] 80% $10,000.00	Deductible/6 months Coinsurance Per lifetime	$ 140.00 50.00	Hospital care Normal delivery	Reduced benefits excludes major medical	Individual $10.22 None Family 22.62 None	 employee[b] system employee system
MASSACHUSETTS												
Springfield												
Blue Cross-Blue Shield	Semi-private for 120 days per illness after [$25.00] deductible	500.00 125.00 50.00	Single operation Appendectomy Tonsillectomy	10.00 5.00	1st day in hospital Thereafter to 120 days	0 100% 80% $5,000.00	No deductible Hospital and medical care Appliances, nursing Per lifetime	Basic coverage 75.00	Hospital care Normal delivery	Same coverage	Individual 3.16 3.16 Family 9.45 9.45	 employee system employee system
MICHIGAN												
Grand Rapids												
Metropolitan Life Insurance	Ward for 365 days per illness (semi-private coverage paid by employee)	450.00	Single operation	5.00	Per day for 365 days in hospital		None	300.00 75.00	Hospital care Normal delivery	Same coverage	Individual .32 8.85 Family 14.50 8.85	 employee (semi) system[b] employee system
Lansing												
Blue Cross-Blue Shield[a]	Semi-private for 365 days per illness	157.50 67.50	Appendectomy Tonsillectomy	15.00 6.00 4.80	1st day in hospital Next 22 days Thereafter to 365 days		None	Basic coverage Fee schedule	Hospital care Normal delivery	Same coverage	Individual 9.09 10.00 Family 23.50 10.00	 employee system employee system
MEA Health Care Insurance[a]	$300.00 plus 75% of $5,000.00 after [$25.00] deductible	300.00	Single operation		Major medical	[$50.00] 80% $10,000.00	Deductible/illness Coinsurance Per lifetime	$200.00 plus 75% of $1,000.00 Fee schedule	Hospital care Normal delivery	Reduced benefits	Individual[b] 6.10 10.00 Family 23.65 10.00	 employee system employee system
MINNESOTA												
St. Paul												
Blue Cross, St. Paul Fire and Marine Insurance Co.	2 or more bed ward for 365 days per illness	200.00 133.35 33.35	Single operation Appendectomy Tonsillectomy	4.00 480.00	Per day for 120 days in hospital Maximum	[$50.00] 80% $10,000.00	Deductible/yr. Coinsurance Per illness	Basic coverage 50.00	Hospital care Normal delivery	N.I.	Individual None 11.88 Family 19.10 17.26	 employee system[b] employee system

1	2	3	4	5	6	7	8	9	10	11	12	13
NEW JERSEY												
Jersey City												
Blue Cross-Blue Shielda/	Semi-private for 120 days per illness and 245 part days	$350.00 175.00 75.00	Single operation Appendectomy Tonsillectomy	$ 10.00 7.00 6.00 5.00	1st day in hospital 2nd-7th day 8th-14th day Thereafter to 365 days		None	7 days $ 150.00	Hospital care Normal delivery	Reduced benefits	 $ 6.02 None 17.81 None	Individual employee system Family employee system
NEW YORK												
Rochester												
Blue Cross-Blue Shield, Aetna Major Medical	Semi-private for 120 days per illness	Fee schedule	Single operations	10.00 5.00	1st day in hospital Thereafter to 120 days	[$50.00] 80% $7,500.00 $15,000.00	Deductible/yr. Coinsurance Per year Per lifetime	$10.00/day for 120 days 75.00	Hospital care Normal delivery	Same coverage	 5.06 5.08 11.27 11.27	Individual employee system Family employee system
Syracuse												
Blue Cross-Blue Shield, Travelers Ins. Co.a/	Semi-private for 70 days per illness	410.00 147.00 61.00	Single operation Appendectomy Tonsillectomy	12.30 8.20 4.10	1st day in hospital 2nd day Thereafter to 120 days	[$100.00] 75% $5,000.00	Deductible/yr. Coinsurance Per lifetime	80.00 75.00	Hospital care Normal delivery	Same coverage	 8.05 Maj. med. 17.70 Maj. med.	Individual employee system Family employee system
Yonkers												
State-wide Plan	Semi-private for 120 days per illness	500.00 175.00 75.00	Single operation Appendectomy Tonsillectomy	7.00 6.00 5.00 4.00	1st-7th day 8th-14th day 15th-70th day 71st-201st day in hospital	[$50.00] 80% $7,500.00 $15,000.00	Deductible/yr. Coinsurance Per year Per lifetime	75.00 75.00	Hospital care Normal delivery	Same coverage	 4.62 4.62 12.75 9.00	Individual employee system Family employee system
Health Insurance Plan	Semi-private for 120 days per illness		Full coverage		Full coverage for hospital, office and home visits	[$50.00] 80% $15,000.00	Deductible/yr. Coinsurance Per lifetime		Full coverage	Same coverage	 5.79 4.62 16.49 9.00	Individual employee system Family employee system
NORTH CAROLINA												
Winston-Salem/ Forsythe Co. (P.O., Winston-Salem)												
Blue Cross-Blue Shield extended benefitsa/	Semi-private for 70 days per illness, extended coverage to 730 days	200.00 100.00 35.00	Single operation Appendectomy Tonsillectomy		Major medical	0 80% $10,000.00	No deductible Coinsurance except for certain scheduled fees Per lifetime	Basic coverage 60.00	Hospital care Normal delivery	Same coverage	 5.15 None 12.89 None	Individual employee system Family employee system
OHIO												
Youngstown												
Blue Crossa/-Blue Shield, Connecticut General Life Insurance Co.	2 or more bed ward for 120 days per illness	200.00 100.00 35.00	Single operation Appendectomy Tonsillectomy	5.00 3.00	1st 2 days in hospital Thereafter to 70 days	[$100.00] 80% $10,000.00	Deductible/illness Coinsurance Per illness	Basic coverage 50.00	Hospital care Normal delivery	N.I.	 8.96 None 21.06 None	Individual employee system Family employee system

DIGESTS OF GROUP HEALTH INSURANCE PLANS FOR PUBLIC-SCHOOL PERSONNEL, 1964-65, MAXIMUM ALLOWANCES AND BENEFITS (Continued)
Dollar amounts shown in () are charges to the individual for the specified benefit.
Dollar amounts shown in [ ] are deductibles which must be satisfied by
the individual before coinsurance can be applied or benefits received.

School system and underwriter of health plan	Hospitalization: Daily room and board	Surgical: Allowances	Surgical: Benefits	Medical: Allowances	Medical: Benefits	Major medical: Allowances	Major medical: Benefits	Maternity provisions for normal delivery: Allowances	Maternity provisions for normal delivery: Benefits	Coverage after retirement	Financing: Cost per month	Financing: Contributor
1	2	3	4	5	6	7	8	9	10	11	12	13
Stratum 3--enrollment 25,000-49,999 (Cont.)												
RHODE ISLAND												
Providence												
Blue Cross and Physicians Servicea/	$22.00/day for 120 days per illness	$404.00 150.00 67.00	Single operation Appendectomy Tonsillectomy	$ 5.00 4.00 406.00	1st 14 days in hospital Thereafter to 102 days Maximum	[$100.00] 80% $10,000.00 $20,000.00	Deductible/yr. Coinsurance Per year Per lifetime	$ 110.00 75.00	Hospital care Normal delivery	None	Individual None $ 7.05 Family 7.05 7.05	 employee system employee system
TENNESSEE												
Hamilton Co. (Chattanooga)												
Tennessee Hospital Service Assoc.	$8.00/day for 70 days per illness	300.00 115.00 50.00	Single operation Appendectomy Tonsillectomy		None	$3,000.00	Or 3 years for specified diseases	10 days 60.00	Hospital care Normal delivery	N.I.	Individual All None Family N.I.	 employee system
Knoxville												
Provident Life and Accident Insurance Co.	$12.00/day for 31 days per illness	300.00 115.00 50.00	Single operation Appendectomy Tonsillectomy		Major medical	[$500.00] 75% $10,000.00	Deductible/yr. Coinsurance Per year	80.00 60.00	Hospital care Normal delivery	N.I.	Individual 7.29 None Family 14.95 None	 employee system employee system
Shelby Co. (excl. Memphis)												
Memphis Hospital Service and Surgical Association	$14.00/day for 31 days per illness	200.00 100.00 40.00	Single operation Appendectomy Tonsillectomy		Major medical	[$100.00] 80% $10,000.00	Deductible/illness Coinsurance Per 36 months	Basic coverage 50.00	Hospital care Normal delivery	N.I.	Individual 50% 50% Family N.I.	 employee system
TEXAS												
Amarillo												
Inter-Ocean Insurance Co.	$10.00/day for 120 days per illness	300.00 100.00 50.00	Single operation Appendectomy Tonsillectomy	5.00 600.00	Per day for 120 days in hospital Maximum		None	125.00 75.00	Hospital care Physicians visits	Same coverage	Individual 4.58 None Family 16.73 None	 employee system employee system
Austin												
Blue Cross-Blue Shield, major medical	$12.00/day for 70 days per illness	300.00	Single operation	5.00	Per day, starts 4th day for 30 days in hospital	[$100.00] 80% $5,000.00 $10,000.00	Deductible/yr. Coinsurance Per year Per lifetime	10 days	Hospital care	N.I.	Individual 6.01 None Family 14.74 None	 employeeb/ system employee system
Corpus Christi												
Blue Cross-Blue Shield, major medical	$12.00/day for 70 days per illness	300.00	Single operation	150.00	Maximum in hospital	[$100.00] 80% $5,000.00 $10,000.00	Deductible/yr. Coinsurance Per year Per lifetime	10 days	Hospital care	N.I.	Individual All None Family N.I.	 employee system

1	2	3	4	5	6	7	8	9	10	11	12	13
Lubbock												
Blue Cross-Blue Shield, major medical	$12.00/day for 70 days per illness	$300.00	Single operation	$ 5.00 150.00	Per day, starts 4th day for 30 days in hospital Maximum	[$100.00] 80% $5,000.00 $10,000.00	Deductible/yr. Coinsurance Per year Per lifetime	10 days	Hospital care	Same coverage	Individual $ 5.69 None Family 14.86 None	 employee system employee system
UTAH												
Davis Co. (Farmington)												
Utah Teachers Welfare Association	3 bed ward for 70 days per illness, thereafter 80% of charges	85%	Of fee schedule by Utah State Medical Association	[25.00] 100% 80%	Deductible/illness Next $75.00 Thereafter	$5,000.00	Per three years for hospital, surgical, and medical	10 days $ 100.00	Hospital care Normal delivery	Same coverage	Individual 1.96 4.58 Family 12.92 5.54	 employee system employee system
Salt Lake City												
Equitable Life Assurance Society	3 bed ward for 70 days per illness	637.50 127.50 63.75	Single operation Appendectomy Tonsillectomy		Major medical	[$100.00] 80% $15,000.00	Deductible/yr. Coinsurance Per lifetime	180.00 100.00	Hospital care Normal delivery	Excludes major medical	Individual None 6.93 Family None 15.40	 employee system employee system
VIRGINIA												
Arlington Co.												
Blue Cross-Blue Shield, major medical	Semi-private for 180 days per illness	300.00	Single operation	5.00 885.00	Per day, starts 4th day to 177 days in hospital Maximum	[$50.00] 80% $10,000.00	Deductible/yr. Coinsurance Per illness	100.00 105.00	Hospital care Normal delivery	None	Individual 7.60 5.07 Family 20.87 13.91	 employee system employee system
Henrico Co.												
Blue Cross-Blue Shield[a]/ major medical	Semi-private for 365 days per illness	150.00 67.00	Appendectomy Tonsillectomy	15.00 10.00 5.00	1st day in hospital 2nd day Thereafter to 70 days	[$100.00] 80% $10,000.00 $20,000.00	Deductible/illness Coinsurance Per year Per 2 or more years	80.00 100.00	Hospital care Normal delivery	N.I.	Individual 7.62 None Family 18.97 None	 employee system employee system
Newport News												
Blue Cross-Blue Shield[a]/ major medical	Semi-private for 365 days per illness	150.00 67.00	Appendectomy Tonsillectomy	15.00 10.00 5.00	1st day in hospital 2nd day Thereafter to 70 days	[$100.00] 80% $10,000.00 $20,000.00	Deductible/yr. Coinsurance Per year Per lifetime	80.00 100.00	Hospital care Normal delivery	N.I.	Individual All None Family N.I.	 employee system
WASHINGTON												
Seattle												
Group Health Cooperative	Full coverage for 180 days per illness		Full coverage		Full coverage	[$25.00] 100% 80% $9,500.00	Deductible/out of area Next $500.00 Coinsurance Per lifetime	(150.00)	Full coverage	Same coverage	Individual 5.00 5.00 Family 25.00 5.00	 employee system employee system
Blue Cross Occidental Life Ins. Co.[a]/	$25.00/day for 100 days per illness	300.00 150.00	Single operation Appendectomy	3.00 300.00 4.00 6.00	Per day in hospital Maximum Office visit Home call, office and home call visits for employee only, start 2nd call for illness, $300.00 max. per year	[100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	100.00 75.00	Hospital care Normal delivery	Same coverage	Individual 5.90 5.00 Family 18.20 5.00	 employee system employee system

DIGESTS OF GROUP HEALTH INSURANCE PLANS FOR PUBLIC-SCHOOL PERSONNEL, 1964-65, MAXIMUM ALLOWANCES AND BENEFITS (Continued)
Dollar amounts shown in () are charges to the individual for the specified benefit.
Dollar amounts shown in [ ] are deductibles which must be satisfied by the individual before coinsurance can be applied or benefits received.

School system and underwriter of health plan	Hospitalization:	Surgical		Medical		Major medical		Maternity provisions for normal delivery		Coverage after retirement	Financing	
	Daily room and board	Allow-ances	Benefits	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits		Cost per month	Contributor
1	2	3	4	5	6	7	8	9	10	11	12	13
Stratum 3--enrollment 25,000-49,999 (Cont.)												
WASHINGTON (Cont.)												
Seattle (Cont.)												
Mutual of Omaha	$25.00/day for 120 days per illness	$ 375.00	Single operation	$ 3.00 150.00 3.00 3.00	Per day in hospital Maximum Office visit Home call, office and home visits for employee only, 33 visits maximum	$5,000.00	Or 3 years for specified dread diseases	$250.00	Lump sum	Same coverage	Individual $ 3.83 4.84 5.00 Family 23.28 5.00	 employee(M) employee(W) system employee system
King County Medical	$25.00/day for 70 days per year	Full coverage	70 days in hospital per year	Full coverage Full coverage	70 days in hospital per year 35 office and home calls for employee only, starts 2nd call for illness	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	100.00 75.00	Hospital care Normal delivery	N.I.	Individual 5.00 5.00 Family 19.60 5.00	 employee system employee system
Tacoma												
Pierce County Industrial Medical Bureau	$24.50/day for 90 days per illness, 30 days for dependents		Full coverage		Full coverage	$2,000.00	Extended coverage	10 days	Hospital care	Same coverage	Individual All None Family N.I.	 employee system
Western Clinic[a]	4 bed ward for 1 month per illness, 50% for next 5 months		Full coverage		Full coverage		None	30 days (25.00)	Hospital care Normal delivery	Reduced benefits	Individual 8.65 9.15 None Family 20.65 21.15 None	 employee(M) employee(W) system employee(M) employee(W) system
WISCONSIN												
Madison												
Blue Cross-Blue Shield	Semi-private for 365 days per illness	1,000.00	Maximum per illness for surgical and medical	1,000.00	Maximum per illness for surgical and medical	[$100.00] 100% 80% $10,000.00	Deductible/90 days Of hospital room and board and physicians charges Coinsurance Per lifetime	10 days 100.00	Hospital care Normal delivery	N.I.	Individual None All Family Dep. cov. Emp. cov.	 employee system employee system
Stratum 4--enrollment 12,000-24,999												
ALABAMA												
Gadsden												
Blue Cross-Blue Shield	Semi-private for 70 days per illness after [$25.00] deductible	200.00	Single operation	3.00	Per day for 70 days in hospital	100% 80% $10,000.00	No deductible Of scheduled hospital and medical care Coinsurance Per lifetime	10 days	Hospital care after [$25.00] deductible	N.I.	Individual All None Family N.I.	 employee system

1	2	3	4	5	6	7	8	9	10	11	12	13
Protective Life Insurance Co.	$12.00/day for 70 days per illness, $7.00/day for 70 additional days	$200.00	Single operation		None		None	$100.00	Lump sum	N.I.	Individual $ 5.95 None Family 12.95 None	 employee b/ system employee system
Calhoun Co., Anniston												
Blue Cross-Blue Shield	Semi-private for 70 days per illness after [$25.00] deductible	200.00	Single operation	$ 3.00	Per day for 70 days in hospital	[$100.00] 80% $5,000.00 $10,000.00	Deductible/yr. Coinsurance Per year Per lifetime	10 days	Hospital care	N.I.	Individual 8.70 11.20 None Family 25.80 None	 employee(M) employee(W) system employee system
ALASKA												
Anchorage												
United Benefit Life Ins. Co.	Major medical		Major medical		Major medical	[$50.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime		None	N.I.	Individual 2.68 2.68 Family 11.51 2.68	 employee system employee system
CALIFORNIA												
Alum Rock Elem. Sch. Dist. (San Jose)												
Kaiser Foundation	Full coverage for 111 days per illness, 60 days for dependents		Full coverage	Full coverage (1.00) (3.50)	In hospital Office visit Home call--routine, no charge after first 2 visits		None	(60.00) (95.00) (140.00)	Full coverage after 10 months' membership For dependents Before 10 months' membership	Same coverage	Individual 7.95 None Family 19.45 None	 employee system employee system
Guardian Life Insurance Co.	$20.00/day for 21 days per illness	350.00 175.00 61.25	Single operation Appendectomy Tonsillectomy	4.00 4.00 4.00	Hospital visit Office visit Home call, 50 visits per year, office and home visits for employee only, start 3rd day for sickness	[$500.00] 100% 75% $10,000.00	Deductible/yr. (basic plan applies) Of scheduled care Private nursing Per illness		None	N.I.	Individual 9.50 None Family 25.88 None	 employee b/ system employee system
Berkeley												
Kaiser Foundation	Full coverage for 111 days per illness		Full coverage	Full coverage Full coverage (1.00) (3.50)	In hospital Office visit, employee Office visit, dependent Home call--routine, no charge after first 2 visits		None	(60.00) (140.00)	Full coverage after 10 months' bership After 10 months' membership	Same coverage	Individual 3.15 5.55 Family 18.20 5.55	 employee system employee system
Blue Cross	3 or more bed ward for 180 days per illness	500.00 175.00 75.00	Single operation Appendectomy Tonsillectomy	5.00 3.00 4.50	Per day for 180 days in hospital Office visit Home call, office and home visits for employee only, start 3rd visit for illness, $255.00 per year	[$50.00] 80% $10,000.00 $20,000.00	Deductible/6 months Coinsurance Per illness Per lifetime	50.00	Hospital care	Same coverage	Individual 5.82 5.55 Family 22.72 5.55	 employee system employee system

DIGESTS OF GROUP HEALTH INSURANCE PLANS FOR PUBLIC-SCHOOL PERSONNEL, 1964-65, MAXIMUM ALLOWANCES AND BENEFITS (Continued)
Dollar amounts shown in () are charges to the individual for the specified benefit.
Dollar amounts shown in [ ] are deductibles which must be satisfied by
the individual before coinsurance can be applied or benefits received.

School system and underwriter of health plan	Hospitalization: Daily room and board	Surgical		Medical		Major medical		Maternity provisions for normal delivery		Coverage after retirement	Financing	
		Allowances	Benefits	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits		Cost per month	Contributor
1	2	3	4	5	6	7	8	9	10	11	12	13
Stratum 4--enrollment 12,000-24,999 (Cont.)												
CALIFORNIA (Cont.)												
Burbank												
Roos-Loos and Independence Life	$25.00/day after [$50.00] deductible per year, with 80% coinsurance to $10,000.00	Full coverage Service fees	For employee For dependents	Full coverage Service fee	For employee For dependents		None	Full coverage Service fee	For employee For dependents	Same coverage	Individual None $ 7.87 Family 12.03 7.87	 employee system employee system
North American Life and Casualty Co.	80% of 3 bed ward or $18.00 for 31 days per illness	80% of $400.00 200.00 60.00	Single operation Appendectomy Tonsillectomy	80% of $ 5.00	Per day for 31 days in hospital	[$200.00] 80% $10,000.00	Deductible/yr. (20% under basic plan does not apply) Coinsurance Per lifetime		None	None	Individual None 8.08 Family 15.18 8.08	 employee system employee system
Cupertino												
Blue Cross	3 or more bed ward for 180 days per illness	300.00 150.00 50.00	Single operation Appendectomy Tonsillectomy	3.00 3.00 4.50	Per day for 180 days in hospital Office visit Home call, office and home visits for employee only, starts 3rd day for illness, $255.00 per year	[$50.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	$ 50.00	Hospital care	Reduced benefits	Individual 8.19 10.34 None Family 20.84 None	 employee(M) employee(W) system employee system
Kaiser Foundation	Full coverage for 111 days per illness, 60 days for dependents		Full coverage	Full coverage (1.00) (3.50)	In hospital Office visit Home call--routine, no charge after first 2 visits		None	(60.00) (140.00)	Full coverage after 10 months membership Before 10 months membership	Same coverage	Individual 7.95 None Family 19.45 None	 employee system employee system
Downey												
Blue Cross, Security Life and Accident Co.	3 bed ward for 180 days per illness	300.00 200.00 50.00	Single operation Appendectomy Tonsillectomy	3.00 3.00 4.50	Per day for 180 days in hospital Office visit Home call, office and home visits for employee only, starts 3rd day for illness, $225.00 a year	[$100.00] 80% $5,000.00 $10,000.00	Deductible/yr. Coinsurance Per illness Per lifetime	50.00	Hospital care	N.I.	Individual Part Part Family N.I.	 employee system
Garden Grove												
New England Mutual Life	Major medical		Major medical		Major medical	[$100.00] 80% $10,000.00	Deductible Coinsurance Per 3 years		None	N.I.	Individual All None Family N.I.	 employee system
Glendale												
Blue Cross	$25.00/day for 365 days per illness	750.00 200.00 75.00	Single operation Appendectomy Tonsillectomy		Major medical	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime		None	N.I.	Individual None 6.00 Family 13.99 7.20	 employee system employee system

1	2	3	4	5	6	7	8	9	10	11	12	13
Palo Alto												
Kaiser Foundation	Full coverage for 111 days per illness, 60 days for dependents		Full coverage	Full coverage (1.00) (3.50)	In hospital Office visit Home call--routine, no charge after first two visits		None	$ (60.00) (95.00) (140.00)	Full coverage after 10 months' membership For dependents Before 10 months' membership	Same coverage	Individual $ 7.95 None Family 19.45 None	 employee system employee system
Riverside												
California Physicians Service[a]	3 or more bed ward for 100 days per illness		Full coverage	Full coverage	For 100 days in hospital, 30 office or home visits per year, starts 3rd day for illness	[$100.00] 80% $20,000.00	Deductible/yr. Coinsurance Per lifetime	50.00	Hospital care	Reduced benefits	Individual 3.21 7.39 Family 19.27 7.39	 employee system employee system
Kaiser Foundation	Full coverage for 125 days per year, 240 days at 1/2		Full coverage	Full coverage (5.00)	In hospital and office visits Home call, no limits		None	(100.00) (175.00)	Full coverage after 10 months' membership Before 10 months' membership	Same coverage	Individual 1.96 7.39 Family 20.06 7.39	 employee system employee system
San Leandro												
Kaiser Foundation	Full coverage for 111 days per illness		Full coverage	Full coverage (1.00) (3.50)	In hospital Office visit Home call--routine, no charge after first two visits		None	(60.00) (140.00)	Full coverage after 10 months' membership Before 10 months' membership	Same coverage	Individual None 8.35 Family 14.75 8.35	 employee system employee system
Blue Cross	3 or more bed ward for 180 days per illness	$300.00 150.00 50.00	Single operation Appendectomy Tonsillectomy	3.00 3.00 4.50	Per day for 180 days in hospital Office visit Home call, office and home visits for employee only, start 3rd day for illness, $225.00 per year	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	50.00	Hospital care	Reduced benefits	Individual Part Part Family N.I.	 employee system
Sweetwater H.S. Dist. (Chula Vista)												
Blue Cross	3 or more bed ward for 180 days per illness	300.00 150.00 50.00	Single operation Appendectomy Tonsillectomy	3.00	Per day for 180 days in hospital	[$100.00] 80% $5,000.00 $10,000.00	Deductible/yr. Coinsurance Per illness Per lifetime	50.00	Hospital care	N.I.	Individual 7.03 8.74 None Family 18.80 None	 employee(M) employee(W) system employee system
San Diego Health Association	3 or more bed ward--$24.00 maximum--for 70 days per illness		Full coverage	Full coverage (1.00) (5.00)	In hospital Office visit Home call		None	Full coverage (100.00)	After 10 months' membership Before 10 months' membership	Same coverage	Individual All None Family N.I.	 employee system
CONNECTICUT												
Bridgeport												
Blue Cross-Blue Shield, Travelers Insurance Co.	$12.00/day for 100 days per illness	350.00	Single operation	6.00 5.00 4.00 500.00	Per day for 1st 4 days, starts 4th day in hospital Next 10 days Thereafter to 120 days Maximum	[$100.00] 80% $5,000.00	Deductible/illness, varies with basic coverage Coinsurance Per illness	125.00 75.00	Hospital care Normal delivery	N.I.	Individual None All Family Dep. cov. Emp. cov.	 employee system employee system

DIGESTS OF GROUP HEALTH INSURANCE PLANS FOR PUBLIC-SCHOOL PERSONNEL, 1964-65, MAXIMUM ALLOWANCES AND BENEFITS (Continued)
Dollar amounts shown in () are charges to the individual for the specified benefit.
Dollar amounts shown in [ ] are deductibles which must be satisfied by the individual before coinsurance can be applied or benefits received.

School system and underwriter of health plan	Hospitalization: Daily room and board	Surgical		Medical		Major medical		Maternity provisions for normal delivery		Coverage after retirement	Financing	
		Allowances	Benefits	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits		Cost per month	Contributor
1	2	3	4	5	6	7	8	9	10	11	12	13
Stratum 4--enrollment 12,000-24,999 (Cont.)												
CONNECTICUT (Cont.)												
Waterbury												
Blue Cross-Blue Shield, major medical	$15.00/day for 120 days per illness	$350.00 135.00 50.00	Single operation Appendectomy Tonsillectomy	$ 6.00 5.00 4.00 500.00	Per day for 1st 4 days, starts 4th day in hospital Next 10 days Thereafter to 120 days Maximum	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	$125.00 75.00	Hospital care Normal delivery	Same coverage	Individual $ 6.21 None Family 15.73 None	 employee system employee system
FLORIDA												
Sarasota Co.												
Blue Cross[a]-Blue Shield, major medical	$16.00/day for 70 days per illness	333.00	Single operation	12.00 5.00	First day in hospital Thereafter to 70 days	[$100.00] 80% $5,000.00 $10,000.00	Deductible/yr. Coinsurance Per year Per lifetime	80.00 80.00	Hospital care Normal delivery	N.I.	Individual 6.75 None Family 20.37 None	 employee system employee system
GEORGIA												
Daugherty Co. (Albany)												
Provident Life and Accident Insurance Co.	$15.00/day for 70 days per illness	300.00	Single operation		None		None	100.00	Lump sum	None	Individual 5.46 None Family 15.29 None	 employee[b] system employee system
ILLINOIS												
Peoria												
Blue Cross Poulsen Plan	Semi-private for 120 days per illness	Fee schedule 75%	Single operation Of unexpected charges to $5,000.00	5.00 450.00	Per day for 90 days in hospital Maximum		None	80.00	Hospital care	Same coverage	Individual 8.62 None Family 24.30 None	 employee system employee system
INDIANA												
Vigo Co., (P.O., Terre Haute)												
Blue Cross-Blue Shield	Semi-private for 120 days per illness	200.00 100.00 35.00	Single operation Appendectomy Tonsillectomy	15.00 10.00 4.00 3.00 117.00	1st day in hospital 2nd day Next 8 days Thereafter to 30 days Maximum		None	Basic coverage 50.00	Hospital care Normal delivery	None	Individual 5.44 None Family 14.01 None	 employee system employee system
Washington Twp. (Indianapolis)												
Blue Cross-Blue Shield	2 or more bed ward for 120 days per illness	Fee schedule	Single operation	15.00 10.00 4.00 3.00	1st day in hospital 2nd day Next 8 days Thereafter to 120 days		None	Basic coverage Fee schedule	Hospital care Normal delivery	N.I.	Individual All None Family N.I.	 employee system

1	2	3	4	5	6	7	8	9	10	11	12	13
IOWA												
Waterloo												
Blue Cross-Blue Shield	Semi-private for 70 days per illness	$400.00 120.00 60.00	Single operation Appendectomy Tonsillectomy	$ 8.00 4.00	1st day in hospital Thereafter to 70 days		None	Basic coverage $ 80.00	Hospital care Normal delivery	N.I.	 $ 5.50 None 12.25 None	Individual employee system Family employee system
LOUISIANA												
Lafayette Parish												
Washington National Insurance Co.	Major medical		Major medical		Major medical	100% [$50.00] 80% $10,000.00	First $500.00 hospital care Deductible/yr. Coinsurance Per lifetime	80% 100.00	For 3 days hospital care (no deductible) Normal delivery	Same coverage	 8% 92% N.I.	Individual employee system Family
MARYLAND												
Harford Co. (Bel Air)												
Blue Cross-Blue Shield[a]	Semi-private for 30 days per illness	340.00 150.00 75.00	Single operation Appendectomy Tonsillectomy	20.00 8.00 6.00	1st day in hospital 2nd and 3rd Thereafter to 30 days		None	75.00 100.00	Hospital care Normal delivery	Same coverage	 6.12 None 16.10 None	Individual employee system Family employee system
MASSACHUSETTS												
New Bedford												
Blue Cross-Blue Shield	Semi-private for 120 days per illness after [$25.00] deductible	500.00 125.00 50.00	Single operation Appendectomy Tonsillectomy	10.00 5.00 500.00	1st day in hospital Thereafter Maximum	$5,000.00	For hospital and medical care for specified illnesses	Basic coverage 75.00	Hospital care Normal delivery	Same coverage	 2.70 2.70 7.10 7.10	Individual employee system Family employee system
MICHIGAN												
Lincoln Park												
Blue Cross[a]/Blue Shield	Semi-private for 365 days per illness	450.00	Single operation, fee schedule related to annual income	Fee schedule	365 days in hospital related to annual income		None	Basic coverage Fee schedule	Hospital care Normal delivery	N.I.	 10.89 None 27.98 None	Individual employee[d] system Family employee[d] system
Saginaw												
Blue Cross[a]-Blue Shield	Semi-private for 365 days per illness	450.00	Single operation, fee schedule related to annual income	Fee schedule	365 days in hospital related to annual income		None	Basic coverage Fee schedule	Hospital care Normal delivery	N.I.	 10.89 None 27.98 None	Individual employee[d] system Family employee[d] system
MINNESOTA												
Bloomington												
Blue Cross-Blue Shield	2 bed ward for 365 days per illness	675.00 180.00 67.50	Single operation Appendectomy Tonsillectomy	16.50 5.50	1st day in hospital Thereafter to 180 days	[$100.00] 80% $10,000.00 $20,000.00	Deductible/illness Coinsurance Per illness Per lifetime	Basic coverage 115.00	Hospital care Normal delivery	N.I.	 3.21 5.00 12.95 8.33	Individual employee[d] system Family employee[d] system

DIGESTS OF GROUP HEALTH INSURANCE PLANS FOR PUBLIC-SCHOOL PERSONNEL, 1964-65, MAXIMUM ALLOWANCES AND BENEFITS (Continued)
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Dollar amounts shown in [ ] are deductibles which must be satisfied by the individual before coinsurance can be applied or benefits received.

School system and underwriter of health plan	Hospitalization: Daily room and board	Surgical		Medical		Major medical		Maternity provisions for normal delivery		Coverage after retirement	Financing	
		Allowances	Benefits	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits		Cost per month	Contributor
1	2	3	4	5	6	7	8	9	10	11	12	13
Stratum 4--enrollment 12,000-24,999 (Cont.)												
MINNESOTA (Cont.)												
Duluth												
Travelers Insurance Co.	$18.00/day to $6,750.00 per illness	$350.00 175.00 52.50	Single operation Appendectomy Tonsillectomy	$ 4.00	Per day in hospital to $1,460.00 per illness	[$100.00] 80% $5,000.00	Deductible/ illness Coinsurance Per lifetime	Basic coverage $ 87.50	Hospital care Normal delivery	N.I.	Individual None Emp. cov. Family $16.00 Emp. cov.	 employee system employee system
MISSOURI												
Springfield												
Continental Casualty Co.a/	$18.00/day for 70 days per illness	400.00	Single operation	5.00	Per day for 70 days in hospital	[$500.00] 75% $10,000.00	Deductible/ illness, basic plan applies Coinsurance Per illness	Basic coverage Fee schedule	Hospital care Normal delivery	Excludes major medical	Individual 9.03 None Family 28.38 None	 employee system employee system
MONTANA												
Billings												
Equitable Life Assurance Society	Major medical		Major medical		Major medical	[$50.00] 100% 80% $10,000.00	Deductible/yr. First $300.00 hospital care Coinsurance Per lifetime	100.00	Lump sum No deductible	Same coverage	Individual 1.57 4.57 Family 12.97 4.57	 employee system employee system
NEVADA												
Washoe Co., (P.O., Reno)												
California Western State Life Ins. Co.	Major medical		Major medical		Major medical	[$50.00] 100% 80% $10,000.00	Deductible/yr. First $500.00 hospital care Coinsurance Per lifetime	100.00	Lump sum No deductible	N.I.	Individual 5.74 4.11 Family 22.96 4.11	 employee system employee system
NEW JERSEY												
Paterson												
Blue Cross-Blue Shield	Semi-private for 120 days per year, 240 part day's care	175.00 75.00	Appendectomy Tonsillectomy	10.00 7.00 6.00 5.00	1st day in hospital 2nd-7th days 8th-14th days Thereafter 365 days		None	7 days 150.00	Hospital care Normal delivery	N.I.	Individual 6.81 None Family 19.82 None	 employee system employee system
NEW MEXICO												
Las Cruces												
Business Men's Assurance Co.a/	$12.00/day for 90 days per illness	375.00 165.00 67.50	Single operation Appendectomy Tonsillectomy	7.50 4.50 246.00	1st-7th day in hospital Thereafter to 50 days Maximum		None	75.00 50.00	Hospital care Normal delivery	N.I.	Individual 4.35 1.09 Family 17.50 1.09	 employee system employee system

1	2	3	4	5	6	7	8	9	10	11	12	13
NEW YORK												
Niagara Falls												
Blue Cross-Blue Shield	Semi-private for 730 days per illness	$500.00 150.00 100.00	Single operation Appendectomy Tonsillectomy	$ 15.00 10.00 5.00 3.00 4.00 5.00	1st day in hospital 2nd day 3rd to 40th day Thereafter to 120 days Office visit Home call, office and home visits only following hospital care, maximum 3 per week	80% $15,000.00	No deductible Of specified care Per lifetime	Basic coverage $100.00	Hospital care Normal delivery	Same coverage	 $ 5.30 5.30 19.88 5.30	Individual employee system Family employee system
OHIO												
Middletown												
Blue Cross-Blue Shield	2, 3 or 4 bed ward for 365 days per illness	300.00 125.00 60.00	Single operation Appendectomy Tonsillectomy	10.00 5.00 4.00	1st day in hospital Next 3 days Thereafter to 120 days		None	Basic coverage 50.00	Hospital care Normal delivery	Same coverage	 7.35 None 18.00 None	Individual employee system Family employee system
Warren												
Blue Shield-Blue Cross	2 or more bed ward for 120 days per year	300.00 125.00 60.00	Single operation Appendectomy Tonsillectomy	10.00 5.00 4.00	1st day in hospital Next 3 days Thereafter to 120 days		None	Basic coverage 50.00	Hospital care Normal delivery	N.I.	 7.75 None 18.01 None	Individual employee system Family employee system
OREGON												
Beaverton												
Blue Cross	4 bed ward, $22.00/day maximum, for 100 days per illness	350.00	Single operation	4.00	Per day for 100 days		None	100.00 50.00	Hospital care Normal delivery	N.I.	 4.70 6.00 None 14.65 None	Individual employee(M) employee(W) system Family employee system
Kaiser Foundation	Full coverage for 111 days per illness, 70 days for dependents		Full coverage	Full coverage (1.00) (5.00)	In hospital Office visit Home call		None	Full coverage (120.00)	After 10 months' membership Before 10 months'	Same coverage	 7.75 None 19.95 None	Individual employee system Family employee system
OPS-Blue Shield	$14.00/day for 70 days per year		Full coverage	Full coverage No charge	For 70 days in hospital For 35 office or home visits per year, starts 2nd visit, for employee only		None	60.00 50.00	Hospital care Normal delivery	Same coverage	 7.30 7.69 None 16.84 None	Individual employee(M) employee(W) system Family employee system
PENNSYLVANIA												
Altoona												
Blue Cross Blue Shield	Semi-private for 120 days per illness	300.00 150.00 50.00	Single operation Appendectomy Tonsillectomy		Major medical	[$100.00] 80% $5,000.00	Deductible/yr. Coinsurance Per lifetime	Basic coverage 90.00	Hospital care Normal delivery	Reduced benefits	 None 5.68 11.02 5.68	Individual employee system Family employee system

DIGESTS OF GROUP HEALTH INSURANCE PLANS FOR PUBLIC-SCHOOL PERSONNEL, 1964-65, MAXIMUM ALLOWANCES AND BENEFITS (Continued)
Dollar amounts shown in () are charges to the individual for the specified benefit.
Dollar amounts shown in [ ] are deductibles which must be satisfied by the individual before coinsurance can be applied or benefits received.

School system and underwriter of health plan	Hospitalization: Daily room and board	Surgical		Medical		Major medical		Maternity provisions for normal delivery		Coverage after retirement	Financing	
		Allowances	Benefits	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits		Cost per month	Contributor
1	2	3	4	5	6	7	8	9	10	11	12	13
Stratum 4--enrollment 12,000-24,999 (Cont.)												
PENNSYLVANIA (Cont.)												
Bethlehem												
Blue Cross-Blue Shield, major medical	Semi-private for 120 days per illness	$300.00 150.00 50.00	Single operation Appendectomy Tonsillectomy	$ 15.00 10.00 4.00 3.00 5.00 7.00	1st day in hospital 2nd day Next 8 days Thereafter to 70 days Office visit Home call, office and home visits for employee only, starts 4th day of illness to 21 days a year	[$100.00] 80% $25,000.00	Deductible/yr. Coinsurance Per lifetime	Basic coverage $ 90.00	Hospital care Normal delivery	Excludes major medical	Individual None All Family Dep. cov. Emp. cov.	 employee system employee system
SOUTH CAROLINA												
Darlington Co.												
Plan A.	Major medical		Major medical		Major medical	100% [$100.00] 80% $10,000.00	First $500.00 hospital care Deductible Coinsurance Per lifetime	200.00	Lump sum	N.I.	Individual 7.35 None Family 18.15 None	 employee system employee system
Plan B.	$11.50/day for 70 days, $4.50/day for 70 additional days per year	150.00	Single operation		None		None	50.00	Lump sum	N.I.	Individual 4.31 None Family 13.32 None	 employee b/ system employee system
Plan C.	Semi-private for 70 days per illness after [$25.00] deductible	250.00	Single operation		None		None	56.25	Normal delivery	N.I.	Individual 4.50 None Family 9.05 None	 employee b/ system employee system
Spartanburg												
Protective Life Insurance Co.	$16.00/day for 70 days per illness	400.00	Single operation	4.00	Per day for 70 days in hospital		None	160.00 100.00	Hospital care Normal delivery	Same coverage except per year rather than illness	Individual 7.50 None Family 15.00 None	 employee b/ system employee system
Blue Cross-Blue Shield	Semi-private for 70 days per illness after [$20.00] deductible	325.00 117.00 48.75	Single operation Appendectomy Tonsillectomy	5.00	Per day for 70 days in hospital, starts 3rd day	$10,000.00	For specified diseases	10 days 71.50	Hospital care Normal delivery	N.I.	Individual All None Family N.I.	 employee system
SOUTH DAKOTA												
Rapid City												
United Benefit Life Insurance Co.	$11.00/day for 70 days per illness after [$25.00] deductible	300.00 150.00 45.00	Single operation Appendectomy Tonsillectomy	3.00 210.00	Per day for 70 days in hospital Maximum	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	110.00 75.00	Hospital care Normal delivery	Same coverage	Individual 1.41 Basic cov. Family 3.27 Basic cov.	 employee system employee system

1	2	3	4	5	6	7	8	9	10	11	12	13
TENNESSEE												
Knox Co. (excl. Knoxville)												
Blue Cross-Blue Shield	$14.00/day for 70 days per illness	$300.00 115.00 50.00	Single operation Appendectomy Tonsillectomy	$ 4.00	Per day for 70 days in hospital, starts 4th day		None	10 days $ 60.00	Hospital care Normal delivery	Same coverage	Individual $ 5.20 None Family 14.60 None	 employee system employee system
TEXAS												
Ector Co., (Odessa)												
Blue Cross-Blue Shield	$12.00/day for 70 days per illness, after [$25.00] deductible	300.00 150.00	Single operation Appendectomy	5.00	Per day for 30 days in hospital, starts 4th day	[$100.00] 80% $5,000.00 $10,000.00	Deductible/illness Coinsurance Per year Per lifetime	10 days 75.00	Hospital care, deductible applies Normal delivery	N.I.	Individual 5.67 4.17 Family 14.55 4.17	 employee system employee system
Goose Creek, (Baytown)												
Blue Cross-Blue Shield	$12.00/day for 70 days per illness, after [$35.00] deductible	300.00 150.00 40.00	Single operation Appendectomy Tonsillectomy	5.00	Per day for 70 days in hospital	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per year	120.00 75.00	Hospital care Normal delivery	N.I.	Individual 5.06 4.17 Family 15.56 4.17	 employee system employee system
Port Arthur												
Business Men's Assurance Co.	$12.00/day for 100 days per illness	300.00 150.00 37.50	Single operation Appendectomy Tonsillectomy	3.00	Per day for 50 days in hospital		None	10 days	Hospital care	Same coverage	Individual All None Family N.I.	 employee[b/] system
UTAH												
Ogden												
Metropolitan Life Insurance Co.	$18.00/day for 70 days per illness	350.00 175.00 70.00	Single operation Appendectomy Tonsillectomy	5.00 3.00 5.00	Per day to $155.00 in hospital Office visit Home call, office and home visits for employee only, starts 3rd day for illness, $250.00 maximum		None	150.00	Normal delivery	Same coverage	Individual 1.44 5.76 Family 4.60 13.80	 employee system employee system
VIRGINIA												
Chesapeake												
Connecticut General Life Insurance Co.	$18.00/day to $1,260.00 per illness	300.00 150.00 45.00	Single operation Appendectomy Tonsillectomy	5.00 350.00	Per day in hospital Maximum	[$100.00] 80% $10,000.00	Deductible/illness Coinsurance Per lifetime	100.00 75.00	Hospital care Normal delivery	N.I.	Individual 2.44 Part Family 13.29 Part	 employee system employee system
WASHINGTON												
Clover Park (P.O., Tacoma)												
Pierce County Medical Bureau	$24.50/day for 90 days per year	Full coverage	For 1 year for any 1 illness	Full coverage	For 1 year for any 1 illness	$2,000.00	Extended coverage per illness	10 days	Hospital care	Same coverage	Individual 8.30 9.60 None Family 21.45 22.55 None	 employee(M) employee(W) system employee(M) employee(W) system

DIGESTS OF GROUP HEALTH INSURANCE PLANS FOR PUBLIC-SCHOOL PERSONNEL, 1964-65, MAXIMUM ALLOWANCES AND BENEFITS (Continued)
Dollar amounts shown in () are charges to the individual for the specified benefit.
Dollar amounts shown in [ ] are deductibles which must be satisfied by the individual before coinsurance can be applied or benefits received.

School system and underwriter of health plan	Hospitalization: Daily room and board	Surgical		Medical		Major medical		Maternity provisions for normal delivery		Coverage after retirement	Financing	
		Allowances	Benefits	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits		Cost per month	Contributor
1	2	3	4	5	6	7	8	9	10	11	12	13
Stratum 4--enrollment 12,000-24,999 (Cont.)												
WASHINGTON (Cont.)												
Edmonds												
Snokomish Co. Physicians Corporation	$18.00/day for 90 days per illness, 30 days for dependents		Full coverage	Full coverage	For 12 months in hospital	$5,000.00	Or 2 years extended benefits for one illness	$ 80.00 Full coverage	Hospital care Normal delivery and physician's visits in hospital	Same coverage	Individual $ 6.75 9.50 None Family 25.45 26.20 None	 employee(M) employee(W) system employee(M) employee(W) system
Blue Cross, Occidental Life Insurance Co.	$20.00/day for 100 days per illness	$300.00 150.00	Single operation Appendectomy	$ 3.00 3.00 5.00	Per day for 100 days in hospital Office visit Home call, office and home visits for employee only, start 2nd day of illness, to $250.00 a year	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per 5 years	100.00 75.00	Hospital care Normal delivery	Same coverage	Individual 8.66 None Family 19.66 None	 employee[b] system employee system
WEST VIRGINIA												
Mingo Co. (Williamson)												
Blue Cross[a] - Blue Shield	$15.00/day for 70 days per illness	125.00 50.00	Appendectomy Tonsillectomy	10.00 5.00 145.00	1st day, starts 3rd day in hospital Thereafter to 30 days Maximum		None	10 days 75.00	Hospital care Normal delivery	Same coverage	Individual 6.60 None Family 15.50 None	 employee system employee system
WISCONSIN												
Kenosha												
Blue Cross-Blue Shield	Semi-private for 120 days per illness	100% of "usual, customary, and unreasonable" charges to a maximum of $1,000.00 per illness					None	Basic coverage Basic coverage	Hospital care Normal delivery	Same coverage	Individual 7.82 None Family 21.74 None	 employee system employee system
WYOMING												
Casper-Midwest (Casper)												
Equitable Life Assurance Society	Major medical		Major medical		Major medical	[$50.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	200.00	Lump sum No deduct.	Reduced benefits	Individual[b/d] 8.85 None Family[b/d] 19.40 18.70 None	 employee system employee(M) employee(W) system

1	2	3	4	5	6	7	8	9	10	11	12	13
Suburban school districts (varies enrollments)												
CALIFORNIA												
Arcadia												
Occidental Life	$12.00/day to $372.00 per illness	Employee $400.00 200.00 60.00 Dependent 300.00 150.00 45.00	Single operation Appendectomy Tonsillectomy Single operation Appendectomy Tonsillectomy	Employee $ 4.50 3.00 4.50 225.00 Dependent 4.50 225.00	Per day, hospital Office visit Home call Maximum start 3rd day of illness Per day in hospital Maximum	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per 5 years		None	N.I.	Individual $ 4.38 None Family 19.56 None	 employee system employee system
Beverly Hills												
Blue Cross	3 or more bed ward for 180 days per illness	300.00 150.00 50.00	Single operation Appendectomy Tonsillectomy	3.00 3.00 4.50	Per day for 180 days in hospital Office visit Home call, office and home visits for employee only, start 3rd day of illness to $225.00 a year	[$100.00] 80% $5,000.00 $10,000.00	Deductible/yr. Coinsurance Per illness Per lifetime	$ 50.00	Hospital care	N.I.	Individual 8.64 10.93 None Family 22.21 None	 employee(M) employee(W) system employee system
CONNECTICUT												
Wethersfield												
Blue Cross-Blue Shield, Travelers Insurance Co.	$23.00/day for 120 days per illness	350.00	Single operation	15.00 10.00 6.00 5.00 4.00	1st day in hospital 2nd day Next 5 days Next 10 days Thereafter to 120 days	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	125.00 75.00	Hospital care Normal delivery	N.I.	Individual[b/][d/] None 8.10 Family 10.61 8.10	 employee system employee system
ILLINOIS												
Skokie												
Blue Cross-Blue Shield, major medical	2 or more bed ward for 120 days per illness	300.00 125.00	Single operation Appendectomy	6.00 4.00	1st 5 days in hospital Thereafter to 120 days	[$100.00] 80% $10,000.00	Deductible/illness Coinsurance Per lifetime	Basic coverage 80.00	Hospital care Normal delivery	None	Individual 4.24 3.50 Family 13.38 11.00	 employee system employee system
Highland Park Elem.												
Blue Cross-Blue Shield	Major medical		Major medical		Major medical	[$100.00] 80% 100% $10,000.00	Deductible/yr. Of $2,000.00 Thereafter Per lifetime	100.00 50.00	Hospital care Normal delivery	N.I.	Individual None 8.52 Family 14.83 8.52	 employee system employee system
Wilmette												
Blue Cross-Blue Shield, Washington National Insurance Co.	Semi-private for 120 days per illness	300.00 125.00	Single operation Appendectomy	6.00 4.00	1st 5 days in hospital Thereafter to 120 days	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	Basic coverage 80.00	Hospital care Normal delivery	N.I.	Individual 90% 10% Family 90% 10%	 employee system employee system

DIGESTS OF GROUP HEALTH INSURANCE PLANS FOR PUBLIC-SCHOOL PERSONNEL, 1964-65, MAXIMUM ALLOWANCES AND BENEFITS (Continued)

Dollar amounts shown in () are charges to the individual for the specified benefit.
Dollar amounts shown in [ ] are deductibles which must be satisfied by the individual before coinsurance can be applied or benefits received.

School system and underwriter of health plan	Hospitalization: Daily room and board	Surgical		Medical		Major medical		Maternity provisions for normal delivery		Coverage after retirement	Financing	
		Allow-ances	Benefits	Allowances	Benefits	Allowances	Benefits	Allowances	Benefits		Cost per month	Contributor
1	2	3	4	5	6	7	8	9	10	11	12	13
Suburban school districts (varies enrollments) (Cont.)												
MASSACHUSETTS												
Brookline												
Blue Cross-Blue Shield	$24.00/day for 120 days per illness	Full coverage	Based on annual income	Full coverage	For 120 days in hospital based on annual income	$5,000.00	Extended coverage for specified illnesses	Basic coverage $ 75.00	Hospital care Normal delivery	Same coverage	Individual $ 3.64 3.64 Family 10.76 10.76	 employee system employee system
MICHIGAN												
Trenton												
Blue Cross[a]/-Blue Shield	Semi-private for 365 days per illness	450.00	Single operation fee schedule related to annual income	Fee schedule	365 days in hospital related to annual income		None	Basic coverage Fee schedule	Hospital care Normal delivery	N.I.	Individual 2.56 8.33 Family 19.65 8.33	 employee system employee system
MINNESOTA												
Roseville (St. Paul)												
Blue Cross, United Benefit Life Insurance Co.	2 or more bed ward for 365 days per illness, after [$25.00] deductible	400.00 200.00 60.00	Single operation Appendectomy Tonsillectomy	4.00 $1,460.00	Per day in hospital Maximum	[$75.00] 80% $5,000.00	Deductible/yr. Coinsurance Per year	Basic coverage 100.00	Hospital care Normal delivery	None	Individual None 8.30 Family 13.59 8.30	 employee system employee system
NEW JERSEY												
Teaneck												
Blue Cross-Blue Shield, Prudential Insurance Co.	Semi-private for 120 days per year, 245 part-days	175.00 75.00	Appendectomy Tonsillectomy	10.00 7.00 6.00 5.00	1st day in hospital 2nd day-7th day 8th-14th day Thereafter to 365 days	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	7 days 150.00	Hospital care Normal delivery	Reduced benefits	Individual 7.34 None Family 21.36 20.80 None	 employee system employee(M) employee(W) system
NEW YORK												
Scarsdale												
Connecticut Life Insurance Company	Semi-private for 70 days per illness	300.00 150.00 45.00	Single operation Appendectomy Tonsillectomy	5.00 350.00	Per day for 70 days in hospital Maximum	[$100.00] 80% $10,000.00	Deductible/2 yrs. Coinsurance Per illness	150.00 75.00	Hospital care Normal delivery	Reduced coverage	Individual 3.54 3.54 Family 11.65 11.65	 employee system employee system
Williamsville												
Blue Cross-Blue Shield, Massachusetts Mutual Life Insurance Co.	Semi-private for 120 days per illness	500.00 150.00 100.00	Single operation Appendectomy Tonsillectomy	15.00 10.00 5.00 3.00	1st day in hospital 2nd day 3rd-40th Thereafter to 120 days	[$100.00] 80% 100% $10,000.00	Deductible/yr. Of $2,000.00 Over $2,000.00/ year Per lifetime	10 days 80.00	Hospital care Normal delivery	Reduced benefits	Individual Bas. cov. Maj. med. Family N.I.	 employee system

1	2	3	4	5	6	7	8	9	10	11	12	13
OHIO												
Beachwood												
Blue Cross-Blue Shield	Semi-private for 120 days per illness	$500.00 165.00 75.00	Single operation Appendectomy Tonsillectomy	$ 15.00 5.00 4.00 675.00	1st day in hospital 2nd to 30th day Thereafter to 120 days Maximum		None	Basic coverage $ 60.00	Hospital care Normal delivery	N.I.	Individual $11.35 None Family 22.70 None	 employee system employee system
Westlake												
Blue Cross-Blue Shield	Semi-private for 120 days per illness	500.00 165.00 75.00	Single operation Appendectomy Tonsillectomy	15.00 5.00 4.00 575.00	1st day in hospital 2nd-30th day Thereafter to 120 days Maximum		None	Basic coverage 60.00	Hospital care Normal delivery	N.I.	Individual 11.85 None Family 23.70 None	 employee system employee system
PENNSYLVANIA												
Cheltenham Twp. (Elkins Park)												
Blue Cross-Blue Shield[a/], I.N.A. Life Insurance Co.	Semi-private for 120 days per illness	300.00 150.00 50.00	Single operation Appendectomy Tonsillectomy	15.00 10.00 4.00 3.00 5.00 7.00	1st day in hospital 2nd day Next 8 days Thereafter to 70 days Office visit Home call, office and home visits for employee only, start 4th visit for illness to 21 visits per year	[$100.00] 80% $10,000.00	Deductible/6 months Coinsurance Per lifetime	6 days 90.00	Hospital care Normal delivery	N.I.	Individual Part Part Family N.I.	 employee system
Fox Chapel												
Blue Cross-Blue Shield[a/]	Semi-private for 30 to 70 days per illness depending on years of continuous coverage	300.00 150.00 50.00	Single operation Appendectomy Tonsillectomy	15.00 10.00 4.00 3.00 5.00 7.00	1st day in hospital 2nd day Next 8 days Thereafter to 70 days Office visit Home call, office and home visits for employee only, start 4th visit for illness to 21 visits per year		None	10 days 90.00	Hospital care Normal delivery	Reduced coverage	Individual None 6.53 Family 11.69 6.53	 employee system employee system
WISCONSIN												
Wauwatosa												
Blue Cross-Blue Shield	Semi-private for 120 days per illness		Full coverage to $1,000.00 per illness		Full coverage to $1,000.00 per illness	[$100.00] 80% $10,000.00	Deductible/90 days Coinsurance Per illness	Basic coverage 75.00	Hospital care Normal delivery	Same coverage	Individual Maj. med. Bas. cov. Family N.I.	 employee system
Whitefish Bay												
Blue Cross-Blue Shield	Semi-private for 365 days per illness	700.00 125.00 50.00	Single operation Appendectomy Tonsillectomy	6.00 3.00	Per day, starts 4th day for 6 days in hospital Thereafter to 70 days	[$100.00] 80% $10,000.00	Deductible/yr. Coinsurance Per lifetime	Basic coverage 65.00	Hospital care Normal delivery	N.I.	Individual 8.05 None Family 21.47 None	 employee system employee system

N.I.--No information.

a/ More than one plan or schedule of benefits is offered by the same underwriter.

b/ The cost per month includes other benefits such as life insurance, accidental death and dismemberment, and income protection from accident or sickness. See the table following this listing.

c/ Cost per month varies with age; the cost at age 40 is reported.

d/ Cost per month varies with annual income; the cost at $6,700 is reported.

BENEFITS INSEPARABLE FROM PACKAGE COST OF INSURANCE PLANS

School system	Life insurance	Accidental death and dismemberment	Income protection
1	2	3	4
Stratum 1			
FLORIDA			
Duval Co.	$1,000	$2,500	
MARYLAND			
Baltimore	1,000		$100 monthly
TEXAS			
Dallas	2,500		
Houston	2,000		
Stratum 2			
ALABAMA			
Mobile Co.	1,000	1,000	100 monthly
FLORIDA			
Orange Co.	1,000	2,500	
LOUISIANA			
Caddo Parish	5,000	5,000	
MASSACHUSETTS			
Boston	2,000	2,000	
MINNESOTA			
Minneapolis	2,000		
Stratum 3			
CALIFORNIA			
Sacramento	2,000	2,000	
GEORGIA			
Cobb Co.	1,000	1,000	25 weekly
ILLINOIS			
Rockford	2,000	2,000	
KANSAS			
Kansas City		1,000	50 weekly
LOUISIANA			
Calcasieu Parish, Employee:	2,000	2,000	
Spouse:	500		
Child:	500		
MICHIGAN			
Grand Rapids	1,000		
Stratum 3 (Continued)			
MICHIGAN (Continued)			
Lansing (MEA Health)			$100 weekly
MINNESOTA			
St. Paul	$1,000	$2,000	
NEVADA			
Clark Co.		1,000	
TEXAS			
Austin	1,000	1,000	
Stratum 4			
ALABAMA			
Gadsden	2,000	3,000	
CALIFORNIA			
Alum Rock Elem.	1,000	2,000	
GEORGIA			
Dougherty Co.	1,000		60 monthly
SOUTH CAROLINA			
Darlington, Plans B and C	1,000	2,500	
Spartanburg	1,000		
TEXAS			
Port Arthur		500	
WASHINGTON			
Edmonds	1,750	1,750	
WYOMING			
Casper-Midwest, Employee:	8,000	8,000	
Spouse:	2,000		
Children:	Varies with age		
Suburban			
CONNECTICUT			
Wethersfield	7,000		

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